

Authorization to Release Medical Records

I, _____, DOB _____ SS# _____
patient name

authorize: _____
physician holding and releasing records

to release the following medical record information to: _____
site receiving medical records

Please initial the appropriate information regarding:

- _____ My physical condition(s) and treatment, including diagnostic studies and records from other providers.
- _____ My mental condition(s) and treatment, including psychiatric/psychotherapy records, and mental health records.
- _____ Drug and alcohol use and treatment.
- _____ Confidential HIV-related information.

These reports are to be used for _____

This consent will terminate _____, unless I earlier revoke my consent.
60 days

patient signature

witness

date

date

This information had been disclosed to you from records protected by Pennsylvania Law. Pennsylvania Law prohibits you from making any further disclosure of this information, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or Is authorized by the Confidentiality of HIV-related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose. (PA 35 PS 7601-7612)