

**PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION**

**Facility Releasing Record:** \_\_\_\_\_  
Name of Organization  
Address: \_\_\_\_\_  
Street City State Zip

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
Last First Middle  
**Address:** \_\_\_\_\_ **Telephone#:** \_\_\_\_\_  
Street City State Zip

**Facility information released to:** \_\_\_\_\_  
Name of Organization  
Address: \_\_\_\_\_  
Street City State Zip

These records may be used for the purposes specified below. I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. The information shall be limited to the hospitalization or treatment specified below:

**Purpose of Request:**

Insurance  Continuing Medical Care  Legal  Personal  Other \_\_\_\_\_

**Date(s) of Service:** \_\_\_\_\_

**Information to be Released:**  Hospital  Clinic  Both Hospital and Clinic

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Inspection of record only | <input type="checkbox"/> X-Ray Reports/Film(s)                           | <input type="checkbox"/> Operative Reports     |
| <input type="checkbox"/> History & Physical        | <input type="checkbox"/> Consultation                                    | <input type="checkbox"/> PT/OT/SP              |
| <input type="checkbox"/> Discharge Summary         | <input type="checkbox"/> Pathology Reports                               | <input type="checkbox"/> Emergency Room Report |
| <input type="checkbox"/> Clinic Notes              | <input type="checkbox"/> All Records (3 years or specified amount) _____ |  |
| <input type="checkbox"/> Laboratory Results        | <input type="checkbox"/> Other: _____                                    |  |

**I specifically authorize the release of information relating to:**

Substance Abuse (drug and/or alcohol)  Behavioral/Mental Health  HIV/AIDS related information

\_\_\_\_\_  
Signature of Patient or Personal Representative Date

**This authorization takes effect on the date below and is valid for (1) year.** Photocopy is valid as original. The request may be canceled at any time by notifying the providing organization. The cancellation will not be valid for information released prior to written notification of the cancellation. ARMC may not condition treatment, payment, enrollment, or eligibility for benefits based on the signing of this authorization. If ARMC requests an authorization for its own use or disclosure of protected health information that it maintains you may inspect or copy the information to be used or disclosed an may refuse to sign the authorization. You are entitled to receive a copy of the signed authorization. NOTE: There may be a charge for copies of medical information. No fees are charged for copies provided for continuation of medical care.

\_\_\_\_\_  
**Signature of patient or legal representative**

\_\_\_\_\_  
**Date**

If not signed by patient – check relationship and list authority to do so. \_\_\_\_\_

Parent  Guardian  POA for Healthcare  Spouse/Adult family member of deceased  Other \_\_\_\_\_

\_\_\_\_\_  
Information Sent by

\_\_\_\_\_  
Date