



Authorization to Release Health Information

Patient Name _____ Date of Birth _____

Address _____

Patient Phone # _____ SSN _____

This information is requested from _____

The information is to be disclosed to the following persons or organizations:

Name _____

Address _____

Requested from Patient Other

The following medical records:

- Entire Medical Record
- History and Physical Exam
- Lab Results
- X-Ray Reports*
- Discharge Summary
- Operative Record
- Progress Notes/Impairment Rating
- Consultation Reports
- Summary of Treatment
- Statement of Account
- HIV/AIDS Test Results & Treatment
- Alcohol & Drug Testing Records

**When a patient requests a copy of their x-rays they will be receiving a copy. The originals have to remain at the MTBJ Clinic. They may also incur a fee for the copies.*

Revocation I understand that I may revoke this authorization at any time by sending a written notice to MTBJ Clinic. However, the revocation will not have any effect on any uses or disclosures MTBJ Clinic may have made before the revocation was received.

Expiration I understand that unless I revoke the authorization earlier, this authorization will automatically expire twelve (12) months after the date this authorization is signed.

Expiration I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

Refusal to Sign I understand that I may refuse to sign this Authorization and that MTBJ Clinic will not refuse treatment as as a result of not signing the Authorization.

Signed this _____ day of _____ 200 _____

Witness _____ Patient/Guardian Signature _____

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