

Authorization for Release of Medical Records

Patient's Name: _____	Date of Birth: _____
Address: _____	
City/State/Zip Code: _____	Phone: _____
Date of Request: _____	Date Needed: _____

Authorization is valid for this request only.

<p>_____ I authorize DCMFMCC to release information to:</p> <p>_____</p> <p>Name of Provider or Facility OR Self</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip Code</p> <p>_____</p> <p>Phone including area code Fax</p>	<p>_____ I authorize DCMFMCC to obtain information from:</p> <p>_____</p> <p>Name of Provider or Facility</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip Code</p> <p>_____</p> <p>Phone including area code Fax</p>
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Types of Records Requested: (Check one)

- _____ All records- no limitations. Records to be released may contain information pertaining to HIV/AIDS, drug and alcohol, psychiatric, and/or mental diagnosis/treatment
- _____ Specific information _____

<p>Purpose of medical record release:</p> <p>_____ Transfer of care</p> <p>_____ Information for additional providers</p> <p>_____ Fax _____ (print name)</p>	<p>Records released for personal use:</p> <p>_____ Mailed Certified Receipt to the address indicated above.</p> <p>_____ I will pick up- ID required and payment required.</p> <p>_____ DCMFMCC Employee verified secure receiving fax.</p>
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I hereby authorize DCMFMCC to release of all my medical information unless limited above to the agency/institution/physician identified. DCMFMCC is not responsible as the released information may no longer be protected by federal Privacy Rules and may be re-disclosed by the recipient.

Signature of Patient or Representative Date

Relationship to Patient (if requester is not the patient)

<p>Requested by: _____</p> <p>Date Request Sent: _____</p> <p>Date Records Received: _____</p>	<p>Reviewed by: _____</p> <p>Date Records Sent: _____</p> <p>Processed by: _____</p>
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