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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Shari Rosen-Schmidt, MD Charisse Barta, MD Sudama Reddi, MD Joel D. Campbell, MD

Patient Name: _____

DOB: _____ Social Security #: _____

Receive Records From: _____ Release Records To: _____

Please send a copy of my records as indicated for date(s) of service (if known): _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Admission/Registration |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> Nurse's Notes | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Films/Discs | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Patient Demographics/Insurance Card | | |

Purpose for releasing medical information: _____

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

 SIGNATURE OF PATIENT / GUARDIAN

 DATE

 PRINTED NAME OF PATIENT OR GUARDIAN

* _____
 RELATIONSHIP TO PATIENT

** If signed by a Legal Guardian, documentation must be attached.*