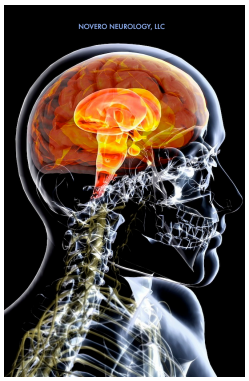

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Medical Records Release
Authorization to Use or Disclose Protected Health Information

Please complete the following:

Name: _____

Address: _____

_____

Phone: _____

SSN: _____ Date of Birth: _____

I authorize the custodian of records for: _____ or other person/entity to disclose or release the following information: (check all that apply)

- ☐ All records
- ☐ Radiology Reports
- ☐ Laboratory/Pathology Reports
- ☐ Physician Notes
- ☐ Other: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient (or patient's personal representative): _____ Date: _____

Printed name of patient representative: _____