CONSENT FORM FOR RELEASE OF INFORMATION

DATE

MED REC # / PID #

PATIENT INFORMATION

NAME

DOB

PHONE

REASON FOR REQUEST

- ☐ PERSONAL COPY
- ☐ CONTINUATION OF CARE DOCUMENTATION
- ☐ LEGAL/INSURANCE

DISCLOSURE INFORMATION *(Release To)*

PERSON/FACILITY/AGENCY

ADDRESS

CITY/STATE/ZIP

PHONE

FAX

OBTAIN FROM *(Request From)*

PERSON/FACILITY/AGENCY

ADDRESS

CITY/STATE/ZIP

PHONE

FAX

SPECIFIC INFORMATION TO BE DISCLOSED/REQUESTED

DATES OF SERVICE: TO

- ☐ ENTIRE RECORD
- ☐ HISTORY & PHYSICAL
- ☐ PRENATAL RECORDS
- ☐ LABS
- ☐ RADIOLOGY REPORTS (XRAY, US)
- ☐ IMMUNIZATION/SHOT RECORDS
- ☐ PROGRESS NOTES
- ☐ OTHER _____

SPECIAL INFORMATION TO BE DISCLOSED/REQUESTED

(Please Initial items requested. By Initialing these you authorize Alivio Medical Center to release this information.)

- ☐ HIV & STD STATUS, REPORT, INFORMATION INITIAL: _____
- ☐ MENTAL HEALTH INITIAL: _____

**I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations. I understand that I may revoke this consent in writing as long as the request has not been fulfilled before time and this authorization is obtained as a condition for obtaining insurance coverage, other law provides, other law provides the insurer with the right to contest a claim under the policy or the policy itself. This consent will expire 6 months from the date signed, unless I specify otherwise. Specified Dates: _____/_____/_____*

PATIENT/PERSON AUTHORIZING RELEASE

NAME

RELATIONSHIP TO THE PATIENT

SIGNATURE

DATE SIGNED

WITNESS

DATE WITNESS