



# 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

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

DATES OF SERVICE:

TO

## 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

SIGNATURE

WITNESS

RELATIONSHIP TO THE PATIENT

DATE SIGNED

DATE WITNESS

**Alivio Medical Center**

An Active Presence for a Strong Community

773.254.1400 | [aliviomedicalcenter.org](http://aliviomedicalcenter.org)