



# CONSENT FORM FOR RELEASE OF INFORMATION

ALIVIO MEDICAL CENTER LOCATION  
WHICH MEDICAL RECORD IS BEING REQUESTED \_\_\_\_\_

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

## OBTAINT FROM (Request From)

PERSON/FACILITY/AGENCY
ADDRESS
CITY/STATE/ZIP
PHONE
FAX

## SPECIFIC INFORMATION TO BE DISCLOSED/REQUESTED

<input type="checkbox"/> ENTIRE RECORD	<input type="checkbox"/> RADIOLOGY REPORTS (XRAY, US)
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> IMMUNIZATION/SHOT RECORDS
<input type="checkbox"/> PRENATAL RECORDS	<input type="checkbox"/> PROGRESS NOTES
<input type="checkbox"/> LABS	<input type="checkbox"/> 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.)

<input type="checkbox"/> HIV & STD STATUS, REPORT, INFORMATION	INITIAL: _____
<input type="checkbox"/> 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