Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient ____ ____/____/____
Full Name DOB

Information Released To:
____
____
____

From:
____
____
____

Please Release the Following:

____ Problem List ____ Progress Notes ____ History/Physical Exam
____ Lab Reports ____ Immunizations ____ X-Ray Reports
____ X-Ray Films ____ EKG Reports ____ Other Diagnostic Reports (Specify) ____________
____ Other (Specify) ____

Including information (if applicable) pertaining to:

____ Mental Health ____ Drug/Alcohol ____ HIV/AIDS ____ Communicable Treatment

Purpose of Need for Disclosure:

____ Continued Patient Care ____ Attorney/Legal ____ Disability Determination
____ Insurance Claim/Application ____ Personal Use ____ Other (Specify) ________________

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

____ __________________
Signature of Patient or Legal Representative Date (MM/DD/YY)

____ ____________________________
Witness Relationship to Patient

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold David E. Bilstrom, M.D., P.C. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

____ __________________
Signature of Patient or Legal Representative Date (MM/DD/YY)

____ ____________________________
Witness Relationship to Patient

------------------------------------**OFFICE USE ONLY**------------------------------------

Date request completed ______________ # pages copied _____ Initials________

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