



## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(Patients Name (Please Print) HealthCare Facility)

It's Director or Designee or health Information Management Department to release information contained in my records, including alcohol and drug abuse records protected under the regulations in code 42 of Federal Regulations, Part 2 if any, and Social Services Records, if any, including communications made by me to a Social Worker or Psychologist, to the individuals or organizations listed below.

According to regulations protected under PA 488, this authorization shall include disclosure of information pertaining to communicable disease or infection which includes, but is not limited to the following. HIV infections, Acquired Immuno-deficiency Syndrome Related Complex, VD, Syphilis, Tuberculosis, Meningitis, Giardiasis, Hepatitis A or B, Histoplasmosis, Legionnaire's Disease, Salmonellosis, Shigellosis, and Staphylococcal Infections.

### **PLEASE RELEASE MY RECORDS TO:**

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NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_  
ZIP: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

The Purpose and Need for Such Disclosure: \_\_\_\_\_

### **Specific Type of Information to be Disclosed:**

☐ Discharge Summary    ☐ History and Physical    ☐ Consultations    ☐ Laboratory Results  
☐ Operative Reports    ☐ Pathology Reports    ☐ X-Ray Reports  
☐ Other: (Specify) \_\_\_\_\_

This content is subject to revocation at any time, except in those circumstances in which the hospital has taken certain records on the understanding that the consent will continue unrevoked until the purpose for which the consent was given with respect to alcohol and/or drug abuse records is satisfied and shall have a duration no longer than that reasonably necessary for the purpose for which it is given.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Social Security Number

\_\_\_\_\_  
Patient Date of Birth