Insights PA

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Authorization for Records Release

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

Doctor Name/Practice Name: _____

Location: _____

Phone: _____ Fax: _____

I authorize the medical professional named above to release my medical record (including, if applicable, information about HIV or AIDS, substance abuse treatment, and mental health services). Specific information requested is as follows:

_____

_____

_____

It is completely your decision whether or not to sign this authorization form. If you sign this authorization, you can revoke it later by sending written notice to the address listed above. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.

I HAVE READ AND UNDERSTAND THIS FORM, AND I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ **Date:** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____

Print Name: _____

Source of authority: _____