montgomery medical associates, pc

Authorization For Disclosure Of Medical Records

1. REGARDING PATIENT:

First Name: .... Last Name: ....

Street Address: ....

City & State: .... Zip Code: ....

Social Security #: .... Birth Date: ....

Home #: .... Work/Cell #: ....

Record Released From (Physician's Name): ....

Physician's Tel: .... Physician's Fax: ....

2. RECORDS RELEASED TO:

Name (i.e. Insurance Co., Lawyer, Physician, Self) ....

Street Address: ....

City & State: .... Zip Code: ....

Telephone: .... Fax: ....

3. INFORMATION TO BE RELEASED: ....

- ☐ Complete Copy of All Records
- ☐ Lab Report
- ☐ Procedure Reports
- ☐ Medical Office Notes
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Itemized Billing Information
- ☐ Other (Please Specify) ....

For the Following Dates: ....

* Special Authorization which requires permission to release otherwise privileged information, please release records pertaining to: (Check Applicable Category)

- ☐ Mental Health
- ☐ Development Disabilities
- ☐ Aids/Aids-Related Illness
- ☐ Alcohol Treatment/Evaluation
- ☐ Drug Treatment/Evaluation
- ☐ HIV Test Result

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4. PURPOSE OR NEED FOR DISCLOSURE: (Check Applicable Category)

☐ Further Medical Care ☐ Payment of Insurance
☐ Legal Investigation ☐ Application for Insurance
☐ Personal ☐ Disability
☐ Relocating ☐ Other: ....

5. The authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

☐ Additional time period, specify please: .... ☐ None

☐ Include future records generated during the additional time period.

6. I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

7. Signature of Patient .... **Date** ....

Patient Guardian/Legal Representative .... **Date** ....

*If signed by person other than patient, please state relationship and authority:

....

Please note that there is an initial charge for printing, as well as, shipping. Patient must prepay prior to processing. Thank you.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

FOR OFFICE STAFF TO COMPLETE:

ID Checked: ☐ Yes ☐ No Copied by: ☐ Staff ☐ MAs
Prepay Required: ☐ Yes ☐ No Prepay Received: ☐ Yes ☐ No

Staff Name: ....

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