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Complete Care Medicine

Authorization For Release of Medical Records

Patient Information (Please Print):

Name:_____ Date of Birth: _____

Social Security Number:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone:_____

Release Information **From**:

☐ Name_____
Address:_____
City:_____ State: _____ Zip Code: _____
Phone: _____ Fax:_____

Release Information **To:**

☐ Name_____
Address:_____
City:_____ State: _____ Zip Code: _____
Phone: _____ Fax:_____

Information to Be Released:

☐ Entire Medical Record, **including** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS

☐ Entire Medical Record, **excluding** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS

☐ Past _____Years

☐ Lab Results

☐ Imaging Results

Other: (Please be as specific as possible, including any information you **DO NOT** want released) _____

☐ _____
_____
_____

Reason for Release:

☐ Personal Copy

☐ Continuation Of Care (Specialist)

☐ Legal

☐ Changing Primary Care Doctors

By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in this document. I understand that this authorization is valid for 1 year unless otherwise specified and I have the right to revoke this authorization at any time by providing a written statement to Complete Care Medicine where the authorization was originally submitted, except to the extent that CCM has already completed action on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

Patient's Signature _____ Date _____

Parent/Legal Representative Signature/Relationship To Pt _____ Date _____