HAMILTON MEDICAL GROUP
AUTHORIZATION TO RELEASE HEALTH INFORMATION

***ALL ASTERISKED ITEMS MUST BE COMPLETED.**

***Patient Name:** ____________________ ***Date of Birth:** ____________________
***Patient Number:** ____________________ ***Social Security#:** ____________________
***Address**: ____________________

***Provider authorized to release the Health Information:**
(Name of Releasing entity)
____
Address: ____________________
____
____

***Entity to receive the Health Information:**
(Name of Receiving entity)
____
Address: ____________________
____
____

***Dates of service of Health Information that is covered by this authorization:**
Start date: ________ **End date:** ________ **Start date:** ________ **End date:** ________

***Health Information related to the patient to be released under this authorization:**
________Complete Health Record
________Immunizations
________Laboratory tests
________Radiology Reports
________Specific Physician ____________________
________Specific Medical Dept. ____________________
________Other (Please specify): ____________________
____

The following information will be released when included in the above unless you indicate otherwise:
________Do not release any AIDS or HIV test results
________Do not release any records of psychiatric care
________Do not release any records of alcohol/substance abuse treatment
________Other: ____________________

***Purpose of disclosure:** ____________________

***Authorization expiration date or event:** ____________________

You may revoke this authorization at any time, except to the extent that we have already relied upon it in making a use or disclosure. A written request to revoke an authorization may be sent to Hamilton Medical Group Medical Records Department.

The Patient has the right to refuse to sign this authorization. Hamilton Medical Group cannot condition treatment, payment, enrollment or eligibility for benefits on the patient providing this signed authorization. When the patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient or any of its agents and/or employees and may no longer be protected by 45 C.F.R. Parts 160 and 164.

A photocopy/facsimile of this authorization may serve as an original. The party receiving the medical records is responsible for the payment of the copying charges.

Records will be rendered after payment and signature are received.

____________________ ____________________
****Patients Signature*** ****Date***

OR

***If patient is a minor or unable to sign for self:**
By my signature below I certify that I am the ____________________ *(relationship)* of the above named patient.

____________________ ____________________ ________
Signature of Patient Representative ***Print Name*** ***Date***

***Verification of identity of person in to whom records are being given, Indicate method of verification:**
____Personal Knowledge **_____Pictured ID** **_____Other (describe):____________________**

Total pages released: ____________ Total Cost: $__________