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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Information Released FROM:	**Please Send My Records TO:**
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
Ph:__________________Fax:____________	Ph:________________Fax:___________

Permission to Fax Information: ☐ Yes ☐ No
I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot always be guaranteed.

Type of Information to Be Released

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist:

______GENERAL MEDICAL RECORDS (CONSISTS OF LAST TWO YEARS) _______LABS (CONSISTS OF LAST TWO YEARS)

______SPECIFIC INFORMATION ONLY: PLEASE SPECIFY______________________________

☐ **PROTECTED OR SENSITIVE INFORMATION**: I understand that certain information cannot be release without specific authorization as required by State/Federal Law. By **initialing**, I authorize the release of the following protected or sensitive information:

_____ DRUG /ALCOHOL DIAGNOSIS/TREATMENT _____MENTAL HEALTH/TREATMENT

_____ GENETIC TESTING INFORMATION _____AIDS/HIV RELATED RECORDS

You have the right to revoke this Authorization at any time, provided that you do so in writing to Restorative Health Clinic. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

This Authorization will expire in 1 year from the date of signing, or unless otherwise specified__________________________.

___________________________________	___________________________
(Print patient Name)	**(Date of Birth)**
___________________________________	___________________________________
(Signature of patient or person authorized by law)	**(Date)**