PLATINUM
PRIMARY CARE

Authorization to Obtain/Release Protected Health Information

Patient Name: _____

Date of Birth:_____

Dates of Service:_____

I, the undersigned authorize the release of, or request access to the information specified below from the medical records of the above-named patient.

All medical information and reports Radiology reports Lab reports

Physical examination reports Immunizations Psychiatric/psychological reports

Patient information is needed for:_____

TO:_____

Office name Phone

_____

Address Fax

FROM:_____

Office name Phone

_____

Address Fax

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses and/or treatment of drug or alcohol abuse, mental illness or communicable disease including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one year from the date of my signature unless I revoke the authorization prior to that time.

Patient/legal representative name:_____

Patient/legal representative signature:_____

Relationship to patient:_____

Date:_____