Authorization for Release of Medical Information

Patient's Full Legal Name: _____

Patient's Preferred Name: _____ Date of Birth: _____

City/State/Zip Code: _____

Social Security #: _____ Phone Number: _____

I authorize Brownstein & Crane Surgical Services to obtain or release medical information with the following individual or organziation:

Name of Provider or Facility: _____

Address: _____

City, State, Zip Code: _____

Phone / Fax #: _____

Purpose for this request:

(Check one.) ❒ Healthcare ❒ Insurance coverage ❒ Personal ❒ Other
❒ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

❒ Immunization history

❒ All medical records related to a specific illness or injury.

_____
Specify illness/injury Date(s) of treatment

❒ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

❒ Specific information (Select one or more, as applicable)

❒ Procedure report ❒ History & physical ❒ Physical Therapy ❒ Laboratory test results
❒ X-ray reports ❒ Other _____
(Please describe.)

❒ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

❒ This request only.

❒ One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

❒ This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____