



# **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient Information:

\_\_\_\_\_  
PRINT Patient Name in Full                      Date of Birth                      Social Security #                      Phone Number(s)

I hereby authorize Steve King, D.O. ("Provider") and his agents and employees to \_\_\_\_ release or \_\_\_\_ obtain (please check the appropriate space) information and copies or records pertaining to my medical care and treatment. **By state law you must be advised that the information you authorize for release may include information that could be considered information about communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiently Syndrome ("AIDS").** In addition, it may include information about mental health, or drug, substance or alcohol abuse.

**Release to:**

\_\_\_\_\_  
Name of designated recipient  
  
\_\_\_\_\_  
Address  
  
\_\_\_\_\_  
City, State, Zip                      Phone Number

**Obtain from:**

\_\_\_\_\_  
Name of designated Facility or Provider  
  
\_\_\_\_\_  
Address  
  
\_\_\_\_\_  
City, State, Zip                      Phone Number

**Information to be Released:**

- \_\_\_\_ All medical records
- \_\_\_\_ The most recent two years of pertinent information (chart notes, labs, x-rays, and special tests)
- \_\_\_\_ All medical billing records
- \_\_\_\_ Specific information (please specify)

**Purpose for which request is being made. Please check one of the following:**

- \_\_\_\_ Physician      \_\_\_\_ Medical Claims Processing      \_\_\_\_ Self      \_\_\_\_ Attorney      \_\_\_\_ Other

**I understand that if I am requesting records/information for release to me or a patient representative:**

- laws may prevent certain records being released to the patient
- in certain situations, records denied for release to the patient may allow patient to request and obtain a review of the denial

**Drug/Alcohol Abuse Treatment Records:** This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rule prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**My Rights:**

I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that Provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

**Reasonable Fee:**

State law provides that a health care provider may charge a reasonable fee.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

\_\_\_\_\_  
Signature of Patient or Patient's Authorized Representative                      Date                      Time

\_\_\_\_\_  
Reason Patient Unable to Sign                      Relationship to Patient

**This Authorization will expire in twelve (12) months or \_\_\_\_\_.**