Regional Medical Associates

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name (print) Birth Date Social Security Number

Address City State Zip

The undersigned hereby authorizes to release the following portions of the medical records of the above named patient:

______ Entire medical record for the period of ____________________________ to ____________________________

______ The following specific portions of the medical record:

__________________________________ for the period of ________________________ to ______________________

Release this information to:

Name of person or institution **Phone** **Fax**

Address of person or institution **City** **State** **Zip**

The medical record is needed for the following purpose:

(State general purpose or intended use of the medical record)

Release information from:

Physician's Name (print) **Phone** **Fax**

Address **City** **State** **Zip**

I understand that I may **REVOKE** this release at any time, in writing, but the request shall remain valid until written Revocation is received by the Medical Records Department. I also understand that this release may include medical records of treatment for **PHYSICAL** and/or **EMOTIONAL ILLNESS**, including treatment of **ALCOHOL** or **DRUG ABUSE**. I also understand that **HIV, AIDS, or AIDS-RELATED INFORMATION** may also be released. A photostatic copy shall be valid as the original authorization. This authorization is valid for 1 year.

Signature Date of Signature

Relationship (if other than patient) Witness

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