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Request and Authorization to Release, Use and /or Share Medical Information

New Federal Privacy Laws require us to obtain patients/parent/legal guardian permission to release, use and/or share patient medical information.

I give my authorization/permission for Dr. Warmuth's office to request, receive, release, pickup, and sign for the medical information described below. I understand that this permission is voluntary. I also understand that once the information is released, used and or shared, the person or organization may share it again. If this happens, the information may no longer be protected under applicable privacy laws. I understand what type of information is going to be released, used and/or shared and how it is going to be done.

Patient's Name____
Patient's address____
City, State, Zip____
Patient's Date of Birth_______________________________________

Please indicate the records below that you would like to be released, used and/or shared.
Biopsy results_______________________________________
Blood work results___________________________________
Office notes____
Films or X-rays_______________________________________
Other Medical Data ___________________________________

If the medical records contains any of the following information, may we release, use and/or share it? If you answered yes, please initial next to each type of information listed here:
Drug and/or alcohol testing_____________
HIV information_____________________
Mental Health Information____________
(A separate form is required for notes taken at a psychotherapy session)

You may give my information to:
Name____
Address____
City, State, Zip____
Telephone: ____
Fax___________________________________

What is the reason for releasing using and/or sharing this information? The information will be released, used and/or shared for these specific reasons:
____

Time Limit: What is the time limit for this permission? Please note, the date you give us cannot be more than 90 days from now.______________________________________

I understand that I may revoke (withdraw) my permission at any time. If I wish to withdraw my permission, I must put this request in writing.
I understand that if I send a letter withdrawing my permission, that letter cannot bring back any information that was already released, used and/or shared. I also understand that it will take time for Dr. Warmuth's office to receive and process my request.

Signature of Patient/Parent /Legal Guardian________________________________

Witness Date