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

EFFECTIVE IMMEDIATLEY: There will be a charge of ***$1.00*** per page for medical records release. Once your request has been received, please allow our office enough time to prepare your records for release.
Medical Records Dept.

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.

Initial: ________________

I authorize the release and copy of:

Full Medical Record ☐ **Labs Only** ☐ **Biopsies Only** ☐

Patient Name: ________________________________ **Date of Birth**: ______________________

Address: ____ **Telephone:** _______________________

City/State/ Zip Code: ____

If my records should contain the following, please **check** which are **authorized** for release.

Drug/Alcohol Testing ____ HIV Information ___ *Mental Health Information ____

You may send my information to:

A separate form is required for notes taken at a psychotherapy session.

Name: ____________________ **Address**: __________________________________

City/State/Zip: _________________________ **Telephone**: ________________________________

Fax: _________________________

What is the reason for releasing using and/or sharing this information?

Changing Physicians ☐ PCP Request ☐ Relocating ☐ Personal File ☐

Signature of Patient/Parent /Legal Guardian: ______________________________

Witness:____**Date:**________

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