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GENERAL SURGERY

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Date

REQUEST FOR RECORDS RELEASE

PATIENT NAME, PREVIOUS NAME IF APPLICABLE

DATE OF BIRTH

TELEPHONE#

PURPOSE OF DISCLOSURE: Patient Care ___ Self ___ Other ___

SEND TO: Provider/Patient/Organization

RELEASED FROM: Provider/Patient/Organization

INFORMATION TO BE DISCLOSED:

I understand that if this authorization includes disclosure of any PSYCHIATRIC, ALCOHOL and DRUG ABUSE records the records are protected by virtue of the provisions of Federal Regulations 42 C.F.R. Part 2. I make this authorization upon the promise that the following notice shall accompany all disclosures of any ALCOHOL AND DRUG ABUSE records made pursuant to this authorization:

> This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains, otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

If Release of information includes Psychiatric, Alcohol, Drug Abuse or HIV results initials are required:_____

I do hereby acknowledge that I have read, am familiar with, and fully understand the terms and conditions of this authorization. We will not condition treatment or payment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPPA of 1996.

PATIENTS SIGNATURE/LEGAL REPRESENTATIVE'S SIGNATURE / DATE

PRINT LEGAL REPRESENTATIVE'S NAME / RELATIONSHIP

WITNESS / DATE

This authorization expires on ___. If no expiration date is indicated, this authorization will expire in 12 months from date of execution. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed.