

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

<i>PATIENT IDENTIFICATION</i>	Name: _____ Address: _____ _____ Telephone: () - _____ Date of Birth: _____ SMG Chart #: _____
<i>PROVIDER</i> <i>[Who has the information you would like released?]</i>	Name: _____ Address: _____ _____
<i>REQUESTOR</i> <i>[Where do you want the information sent?]</i>	Name: _____ Address: _____ _____
<i>INFORMATION TO BE RELEASED</i>	<input type="checkbox"/> Clinic Notes <input type="checkbox"/> Lab Results <input type="checkbox"/> X-Ray Results <input type="checkbox"/> Immunizations <input type="checkbox"/> EKG Results <input type="checkbox"/> Pathology Results <input type="checkbox"/> All Records <input type="checkbox"/> Other [ie: specific dates] _____ _____ _____
<i>REASON FOR RELEASE</i>	<input type="checkbox"/> Medical Treatment <input type="checkbox"/> Insurance <input type="checkbox"/> Legal/Attorney <input type="checkbox"/> At My Request
<ul style="list-style-type: none"> ▪ I authorize the PROVIDER to release the requested medical information to the REQUESTOR. All records pertaining to psychiatric/mental health, chemical dependency and/ or HIV/AIDS related illness/testing will be released as authorized unless I have limited this as noted in the INFORMATION RESTRICTIONS section above. ▪ I understand that this release will automatically expire one year from the date of my signature and that I may revoke it at any time by notifying the provider in writing; the revocation will take effect when the provider receives my written notice. I understand that my revocation does not affect prior disclosures or actions made or taken in reliance on this authorization. ▪ I understand that once the Provider has disclosed health care information that I have authorized to be disclosed, the Provider has no control over this information. The person or organization that I authorized to receive the information might re-disclose it. The information may no longer be protected by privacy laws. ▪ I understand that Stillwater Medical Group will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. ▪ I understand that there may be a retrieval and copy charge associated with this release. <p>Signature of Patient: _____ Date: _____</p> <p>Or: _____ Date: _____</p> <p style="text-align: center;"><input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Authorized Representative <i>Check relationship to patient</i></p>	