

**Authorization to Release Medical Information FROM MMCS Clinic**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Former Name \_\_\_\_\_  
Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_ SS# \_\_\_\_\_

**I authorize information to be sent to:**

\_\_\_\_\_  
Physician/or other third party named

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

**Purpose of Release: check one box**

- Referral/Consultation \*
- Legal \*\*

\* Records sent to outside physicians/clinics are provided as a courtesy.

\*\* Fees may apply: the rate is \$25 for the first 10 pages and .25 cents each additional page plus postage.

**INDICATE TYPE OF INFORMATION TO BE RELEASED BELOW**

   **General Medical Records** –excluding protected records.

Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports and immunizations. Please contact the Release of Information office directly if additional information is needed.

**-ORSpecific**

**Information Only:**

   History and Physical specify date \_\_\_\_\_  
   Other \_\_\_\_\_

**Protected or sensitive information:** I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information.

   DRUG ABUSE DIAGNOSIS/TREATMENT \_\_\_\_\_ SEXUALLY TRANSMITTED DISEASES

   ALCOHOLISM DIAGNOSIS/TREATMENT \_\_\_\_\_ AIDS/HIV TEST RESULTS INCLUDING

RELATED HIGH RISK BEHAVIOR  
   MENTAL HEALTH/TREATMENT \_\_\_\_\_ GENETIC TESTING

•By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

•You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

•You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

\_\_\_\_\_  
Signature of patient or legally responsible person relationship to patient date