



Authorization for Release of Medical Information

Member Name: _____

Social Security: _____ Date of Birth: _____

I allow _____ (PCP/Facility) to release part or all of my medical records. **This includes:**

- alcohol and drug records
- mental health records
- information given by me to social workers or psychologists

This information is needed for the following reason(s):

Please select one of the options below:

- I agree to release of my records. May include records listed above.
- I do not want these items below released with my records:
 - Alcohol record/info
 - Drug record/info
 - Mental Health record/info
 - Report/information from psychologist(s) and/or social worker(s)
 - Other. Please list here: _____

Please release a copy of my medical records to:

Name	Address	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing this, I understand that:

- I waive the private status of my records for the reason above.
- This consent shall be in effect for one year or through this treatment. Whichever is longer.
- I may cancel this at any time by written notice to the above provider and the Plan.

I have read and understand this form and its contents.

Signature of Patient (guardian, if patient unable to sign) _____ Date _____

Relation to patient, if signed by guardian _____ Date _____

Witness _____ Date _____