



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

I authorize the LiveOn Medical Center to disclose the health information as directed below by fax or by mail to the address specified below.

Provider Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

RECORDS AUTHORIZED TO BE RELEASED:

- Office Notes (complete medical record)
Outpatient records
Psychiatric and other mental health records
Records relating to drug or alcohol abuse
Lab reports
Radiological images (x-rays)
Consultation notes or reports
HIV and/or AIDS related information
Other

PLEASE SEND MY HEALTH RECORDS TO (Please Print Clearly):

Blank lines for recipient address

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the healthcare provider, but that revoking this authorization will not affect disclosures made or actions taken before revocation is received.

I also understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
Federal privacy regulations will no longer apply to the information disclosed, and that may re-disclose the information.
A copy of this authorization may be utilized with the same effectiveness as an original.

PATIENT OR REPRESENTATIVE ( PLEASE SIGN ) \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF REPRESENTATIVE (PLEASE PRINT) \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_