

DICKSON MEDICAL ASSOCIATES, P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of information from the medical record of :

Patient Name: _____ Patient Date of Birth: _____

Home Phone: () _____ Cell Phone: () _____

Patient Address: _____ City _____ State _____

Information released from:

Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____

Fax Number: _____

Information released to:

Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____

Fax Number: _____

Please release the following information:

- | | | |
|--|---|--|
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> HIV/AIDS Test |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Drug/Alcohol |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Radiology Films | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> EKG Reports | <input type="checkbox"/> EEG Reports | |
| <input type="checkbox"/> Other Diagnostic Reports (specify) _____ | | |
| <input type="checkbox"/> Reports/Correspondence from other providers | | |

This information is necessary for the following purpose:

- | | | |
|---|--|---|
| <input type="checkbox"/> Continued patient care | <input type="checkbox"/> Personal use | <input type="checkbox"/> Attorney/Legal |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (Specify) _____ | |

Informed consent for Release of Confidential Information

I understand that:

- I may revoke this consent in writing at any time, except to the extent action has already been taken.
- This consent will expire 90 days after the date of my signature, unless otherwise specified.
- I understand that there is a fee for copy service rendered.
- I understand that this information may include HIV/AIDS, Mental Health, Chemical Dependency, Sexually Transmitted Disease diagnosis, treatment and test results.
- I understand that the information released is for the specific purpose stated above.
- I understand that my medical records may contain reports that only a physician can interpret.
- I understand and have been advised that I should contact my physician regarding entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
- I will not hold DICKSON MEDICAL ASSOCIATES liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation.
- I understand that payment of the above fee is due prior to my records release and that within ten (10) working days of receipt of payment, my records will be available.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness

For office use:

Date request completed: _____

#pages copied _____

Charges \$ _____

Initials _____