AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE FILL OUT ALL SECTIONS

Patient's Name (print clearly)_____

Date of Birth_____ SSN_____

Contact Telephone # Home_____ Cell_____

Information RELEASED FROM:	**Information RELEASED TO:**
_____ **(Facility)**	_____**(Facility)**
_____ **(Address)**	_____**(Address)**
_____ **(City, State, Zip)**	_____**(City, State, Zip)**
_____ **(phone)**	_____ **(phone)**
_____ **(fax)**	_____ **(fax)**

Reason for Request:_____

Information to be released:
____Complete health records _____Immunization Record Only
____Office notes – dates from_____to _____
____Lab Reports – dates from_____to_____
____X-Ray Only – dates from_____to_____ Area of Body_____
____Other_____

☐ **I DO or ☐ I DO NOT authorize the release of information related to:**
AIDS (Acquired Immunodeficiency Syndrome), HIV (Human Immunodeficiency Virus) Infection, Psychiatric Care and/or Psychological assessment and treatment for alcohol and/or drug abuse.

Copying fees for records provided by Ashland Medical Center are $0.50 per page for the initial 50 pages and $0.25 per page for each additional page, plus $10 processing fee. Copying fees for x-ray films is a minimum of $25 and $25 for each additional set of three films.
I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by Federal Regulations. I need not sign this form in order to assure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____Date_____
Signature of the patient, parent/guardian if minor or authorized representative

If signed by person other than patient, state relationship to patient:_____

Ashland
Medical Center
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