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Release of Information Authorization Form

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize AMS to **obtain** my medical records from _____

I hereby authorize AMS to **release** my medical records to: [] Myself [] Other: _____

How Should Information Be Released? (check all that apply):

- In-Person Pickup**
- Email** – Email Address: _____
- Fax** – Fax Number: _____
- Mail** – Address: _____
- Other:** _____

Purpose of Disclosure:

- Continuity of Care
- Legal
- Insurance
- Personal
- Other: _____

Information to Be Released (check all that apply):

- Complete Medical Record
- Chart Notes: All or Date: _____
- Lab Reports: All or Date: _____
- Radiology: All or Date: _____
- Other (please specify): _____

The following items must be initials to be include in the medical record request:

- _____ HIV/AIDS related to health information
- _____ Mental Health information
- _____ Drug/alcohol diagnosis, treatment, and/or referral information

Authorization Expiration

This authorization will expire 365 days from the date signed or on this date: _____

Patient Rights & Acknowledgments

- I understand that I may revoke this authorization at any time by providing written notice..
- I understand that any revocation will not apply to information already released in reliance on this authorization.
- I understand that my treatment or payment cannot be conditioned on the signing of this authorization.
- I understand that once information is released pursuant to this authorization, it may no longer be protected under HIPAA privacy regulations.

Patient or Legal Representative Signature: _____ Date: _____