Paul V.B. Hyde, M.D., F.C.S., F.R.C.S., F.A.C.S

Mark J. Sherman, M.D., F.A.C.S.

Cheryl L. Olson, M.D., F.A.C.S.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION:

I hereby authorize: ____

Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: ____

Name

____

Address

____

City State Zip Code

____

Phone Number Fax Number

The medical information/records will be used for the following purpose: _________________

RECORDS TO BE RELEASED:

[ ]Physician Notes [ ]Imaging Studies [ ]Lab Studies [ ]All [ ]Other: ______________

Date Range: ___________ to ___________

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse: _____(initial)
Psychiatric/Mental Health: _____(initial)
Tests for Antibodies to HIV: _____(initial)
HIV Diagnosis/Treatment:______(initial)
Genetic Information: ______(initial)

This authorization to obtain records will expire on __________________. If an expiration date is not written it will expire one year from the date signed below.

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient *or legal/personal representative* | Relationship *if other than patient*

Patients Name (PRINT) | Date

Patient's Date of Birth | Phone Number