



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please Fill Out Completely

Patient's Name: _____ Patient's Date of Birth: _____
(Include previous/maiden named used, if applicable)

Patient's Address: _____

City: _____ State: _____ Zip Code: _____ Phone No.: _____

Patient's Social Security No.: _____

~ I HEREBY REQUEST AND AUTHORIZE:

Health care provider **RELEASING** Information

Address

City State Zip Code

~ TO DISCLOSE TO:

Person **RECEIVING** Information

Name

Address

City State Zip Code

A complete copy of all of the above named patient's medical records, including all records relating: to mental health, drug or alcohol related conditions, AIDS/HIV status or sexually transmitted disease, if applicable.

INCLUDE DATE(S) OF SERVICE: _____

A copy of the above named patient's medical records, **limited to the following:** _____

INCLUDE DATE(S) OF SERVICE: _____

Actual X-Ray films or copies: These films are part of your permanent record and are released on a loan basis only. **Please return these films within thirty (30) days of receipt.**

INCLUDE DATE(S) OF SERVICE: _____

The purpose or need to disclose these records is:

Continuing Care Insurance coverage change Other (Specify) _____

I have read and understand the nature of this release of information as indicated above. This authorization and request shall be valid **until the disclosure is complete or up to 90 days** after the date below, after which time it shall expire. **I understand that I may revoke this authorization in writing at any time up to the time this request has been fulfilled or any other action has been taken in reliance on this request by submitting in writing my revocation to the above named healthcare provider.**

A photocopy or facsimile of this authorization will be considered valid as an original.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization.

I understand that, if persons or organizations I authorize to receive and/or use the protected health information described above, are not health plans, covered health care providers or health care clearing houses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

PMA and its subsidiaries, affiliates, employees and officers, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Upon signature, you are entitled to a photocopy of this Authorization for the Release of Health Information form.

Patient Signature

Date signed

Parent/Legal Guardian/Authorized Representative

Date signed

Relationship to patient