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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ HEREBY AUTHORIZE:

NAME: _____
(HEALTHCARE PROVIDER THAT WILL SEND RECORDS)

ADDRESS: _____

PHONE: _____ FAX: _____

TO DISCLOSE THE MEDICAL INFORMATION BY MAIL/FAX TO:

NAME: _____
(HEALTHCARE PROVIDER TO RECEIVE RECORDS)

ADDRESS: _____

PHONE: _____ FAX: _____

FROM THE HEALTH RECORDS OF:

NAME: _____

ADDRESS: _____

DOB: _____ SS#: _____

FOR THE PURPOSE OF: _____

_____ STATEMENTSOF CHARGES OR PAYMENTS
_____ RECORDS OF VISITS
ALL/SPECIFIC DATES TO INCLUDE: _____
_____ IMMUNIZATIONS
_____ LAB REPORTS
_____ XRAY/RADIOLOGY REPORTS
_____ OTHER _____

THIS AUTHORIZATION IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. ANY AND ALL RECORDS, WHETHER WRITTEN OR ORAL IN ELECTRONIC FORMAT, ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT MY PRIOR WRITTEN AUTHORIZATION, EXCEPT AS OTHERWISE PROVIDED BY LAW.
2. A PHOTOCOPY OR FAX OF THIS AUTHORIZATIONIS AS VALID AS THIS ORIGINAL.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT WHERE INFORMATION HAS ALREADY BEEN RELEASED. THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED. THE REVOCATION MUST BE IN WRITING.
4. WILLIAM H ST MARTIN MD, ITS EMPLOYESS, AND PHYSICIANS ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.
5. TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED UPON OBTAINING THIS AUTHORIZATION.
6. INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT IS NO LONGER PROTECTED.

_____ DATE: _____
(PRINT PATIENT'S NAME)

_____
(PATIENT'S SIGNATURE OR GUARDIAN IF MINOR)