

Medical Records Release Form

I voluntarily consent to authorize my health care provider/s from **Frontier Medical & Behavioral Center** _____ to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____ Ph: _____ Fx: _____

Address: _____ Email: _____

Purpose: I authorize the release of my health information for the following specific purpose:
[] At request of the patient [] Collaboration of Care [] Other: _____

Information to be disclosed:

I authorize the release of the following health information: (check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.¹
- Only the following records or types of health information:
_____.

Term: I understand that this Authorization will remain in effect:

- From the date of this Authorization until the ____ day of _____, 20__.
- Until the Provider fulfills this request.
- Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient Printed Name	Guardian Printed Name (If Minor)	Relationship
Patient Signature	Guardian Signature	Date:
