AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient Full Name: _____ Date of Birth:_____

Patient Address: _____ Home Phone:_____

City: _____ State: _____ Zip Code: _____ Work Phone: _____

Release Information To

I hereby authorize TopCare Medical, PA to release my medical record information to:

◯ Mail Copies to ◯ Hold for Patient to Pick-up ◯ Discuss Medical Information With:

Name/Facility: _____ Attention:_____

Address: _____ Phone:_____

City: _____ State: _____ Zip Code: _____ Fax: _____

Purpose of Request: ◯ Personal ◯ Continuing Care (second opinion / refer to specialist) ◯ Insurance ◯ Legal

◯ Transfer out (please specify reason)_____ ◯ Other (please specify)_____

Information to be Released

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon one (1) year.

I also understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

_____ _____

Signature of Patient or Legal Representative Date

Authorization to Release Protected Information

Please put a checkmark in **ALL** the check boxes below, indicating how protected information should be handled even if the categories are applicable or not to the patient's medical records. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

		Initials
I DO ☐	☐ **DO NOT** want All Medical Records released	_____
I DO ☐	☐ **DO NOT** want Psychiatric Treatment Notes released	_____
I DO ☐	☐ **DO NOT** want information about Mental Health released	_____
I DO ☐	☐ **DO NOT** want information about HIV Tests & related information released	_____
I DO ☐	☐ **DO NOT** want information about Alcohol and/or Substance Abuse released	_____
I DO ☐	☐ **DO NOT** want information about (other sensitive information)_____ released	_____

_____ _____

Patient's Signature **Date**

_____ _____

Parent / Legally Recognized Representative Signature **Date**

_____ _____

Witness **Date**

This document is for office use only.

Date req. Complete:_____ # of pages copied_____ Reviewed by_____