# Patient Authorization To Obtain Outside Medical Records

Patient Name: _____ Social Security Number: _____

Previous Name, if applicable: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

I authorize Harbin Clinic provider: _____to obtain all or part of my medical record, which may include treatment for drug abuse, child abuse, AIDS, alcoholism or mental illness.

The purpose for which the following information is being requested: _____

**My records need to be obtained from the following Doctor/Facility:**

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____Fax: _____

**Send Health Information To:**

Name: _____ Address: _____

City: _____ State: _____ Zip _____

Fax Number: _____ Phone Number: _____

**Dates and Type of Information to disclose:**

- ☐ 2 years prior from last date seen
- ☐ Dates other: _____

**Records authorized to be released are listed below. In the event that the information checked below includes reference to a mental health or drug and/or alcohol condition, treatment, or diagnosis, I authorize the release of that information.**

**Please check the appropriate item(s):**

| | | | |
|---|---|---|---|
| ☐ ER Record/Dictation | ☐ History and Physical | ☐ Progress Notes | ☐ Consultation |
| ☐ EKG(s) | ☐ Discharge Summary | ☐ Surgery report | ☐ Labs (incl. HIV) |
| ☐ X-Ray report | ☐ Pathology Report | ☐ Doctor's orders | ☐ Medications |
| ☐ Itemized bill | ☐ Genetic testing | ☐ Other _____ | |

I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon this authorization.

If not previously revoked, this authorization will terminate on the following date, event or condition: _____. If no date, event or condition specified, this authorization will expire after 60 days.

I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization.

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

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

I understand I am entitled to a copy of this authorization.

**Signature of Patient (or Patient's Representative):_____Date:** _____

**Description of Authority to Act for Patient**: _____