Beckett Ridge
FAMILY MEDICINE

Authorization for Release of Medical Information

Patient Name: _____ Phone: _____

Address: _____ Date of Birth: _____

Last 4 Digits of Soc. Sec. # (optional): _____ Maiden Name (if applicable): _____

Records from:	**Records to:**
Address:	Address:
Phone/Fax:	Phone/Fax::

➢ Information to be released at the request of the individual for continuation of medical care (choose one):

☐ All medical records *

* Only the most recent two (2) years initially, additional dates can be requested when/if necessary.

☐ Only medical records related to a specific treatment and/or date(s) of service:

List treatment and/or applicable date(s): _____

Note: When sending information to our office, *records containing more than 20 pages should be mailed, not faxed.*

The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that except to the extent that action has already been taken based on my authorization, this authorization can be revoked at any time through written notification to the parties involved. I understand that the information disclosed pursuant to the authorization could be redisclosed by the recipient and may no longer be protected by Federal law. I understand that this authorization is voluntary; refusal to sign will not impact my ability to receive treatment.

I understand that, if applicable, the information to be disclosed may include details pertaining to testing/diagnosing/treating drug and/or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS), and/or testing for antibodies to the AIDS virus (HIV).

This authorization will expire six (6) months from the date of signature unless specified otherwise here: _____

Signature (patient or legal representative**): _____ **Date**: _____

** Name/Relationship to Patient (if signed by legal representative): _____

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