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Request for Release of Medical Information

Patient Information: Name: _____

Birthdate: _____ Age: _____

SSN#: _____ Ph. #: _____

I do not wish to release my medical information to anyone _____

Provide My Medical Information Upon Request To:

Name	Date of Birth	Social Security Number	Relationship to Patient

****If requesting a patient portal family account "all records" and "all dates" must be checked****

The information that I request to be released is:

- ALL RECORDS
- EKG Reports
- Laboratory Results
- Psychotherapy notes _____
Initial
- Progress Notes Only
- Imaging Reports
- History & Physical Exam Note
- AIDS/HIV/STD Information

The time period of records I request to be released includes:

- ALL DATES
- From _____ to _____

Purpose of release: PERSONAL USE Attorney/Legal request Other _____

I authorize the release of information as described above from Moscow Family Medicine. This authorization will expire **one year** from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

If the patient is aged 14 years or older, only the patient may authorize release and/or disclosure of information related to sexually transmitted disease. I understand that my signature below authorizes release of this information. Authorization is valid for 1 year unless revoked earlier, and I can revoke this authorization by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

Patient or Guardian Signature **Date**
 Relationship to Patient _____

Minor Aged 14-17 Signature **Date**