

# General Medical Release Form

## Authorization For Use or Disclosure of Imaging Information

This authorization for use or disclosure of my health information is required by state and federal law.

PATIENT'S NAME \_\_\_\_\_ DOB: \_\_\_\_\_  
Last First MI

Daytime Telephone Number \_\_\_\_\_ Social Security No: \_\_\_\_\_

## I Hereby Authorize The use or Disclosure of My health Information

\_\_\_\_\_  
(name of person or organization releasing information)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
CITY STATE ZIP CODE

## To Release my Health Information To:

\_\_\_\_\_  
(name of person or organization releasing information)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
CITY STATE ZIP CODE

## This Authorization Applies To The Following Information:

- All records  
  Lab  
  Imaging Reports  
  Immunization  
 Other: \_\_\_\_\_

## The Recipient May Use My Health Information Only For The Following Purpose:

**(Please Specify)**

A specific authorization is required to release information regarding the following:

	YES	NO	INITIALS
HIV Information	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug/Alcohol Information	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health Information	<input type="checkbox"/>	<input type="checkbox"/>	_____

I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to address on the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION. COPY Requested:  Yes  No Copy Received m

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient/Personal Representative Signature \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_