montgomery medical associates, pc

Authorization For Disclosure Of Medical Records

1. REGARDING PATIENT

First Name:	Last Name:
Street Address:	
City & State:	Zip Code:
Social Security #:	Birth Date:
Home #:	Work/Cell #:

Record Released From (Physician's Name/Facility/Hospital):_____

Tel: _____ Fax: _____

2. RECORDS RELEASED TO

Name (I.e. Insurance Co., Lawyer, Physician, Self)	
Street Address:	
City & State:	Zip Code:
Telephone:	Fax:

3. INFORMATION TO BE RELEASED:

☐ Complete Copy of All Records
☐ Procedure Reports
☐ Radiology Reports
☐ Itemized Billing Information
☐ Lab Report
☐ Medical Office Notes
☐ Pathology Reports
☐ Other (Please Specify) _____

For the Following Dates: _____

* Special Authorization which requires permission to release otherwise privileged information, please release records pertaining to: (Check Applicable Category)

☐ Mental Health
☐ Aids/Aids-Related Illness
☐ Drug Treatment/Evaluation
☐ Development Disabilities
☐ Alcohol Treatment/Evaluation
☐ HIV Test Result

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4. PURPOSE OR NEED FOR DISCLOSURE: (Check Applicable Category)

☐ Further Medical Care
☐ Legal Investigation
☐ Personal
☐ Relocating
☐ Payment of Insurance
☐ Application for Insurance
☐ Disability
☐ Other: _____

5. The authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

☐ Additional time period, specify please: _____ ☐ None
☐ Include future records generated during the additional time period.

6. I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

7. Signature of Patient _____ Date _____
Patient Guardian/Legal Representative _____ Date _____

*If signed by person other than patient, please state relationship and authority:
_____

8. ***Please note that there is an initial charge for printing as well as shipping. Patients must prepay prior processing. Thank you.***

9. Office Pick up, fax or mail medical records – Must bring or fax the following items:

1. **A completed Authorization for Release of Medical Records**
2. **A legible photocopy of your valid photo ID**
3. **A check, money order or credit card for payment**

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This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

FOR OFFICE STAFF TO COMPLETE:

ID Checked:	☐ Yes	☐ No	Copied by:	☐Staff	☐MAs
Prepay Required	☐ Yes	☐No	Prepay Received:	☐ Yes	☐No

Staff Name _____