Medical Records Release Form

Please complete the following medical release consent that will allow your providerto coordinate your care with your primary care physician.

Patient Name:_____Patient ID#_____DOB _____

Address:_____

Dates of Treatment: _____

This consent authorizes release or disclosure of information from the medical records of the above named patient to:

MD:_____Phone: _____

Address: _____

The information to be disclosed is limited to: (mark items to be disclosed)

- ☐ Entire Record
- ☐ Progress Notes
- ☐ Drug/Alcohol Treatment
- ☐ Mental Health Treatment History
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Social History
- ☐ Psychological Testing Results
- ☐ Diagnostic Evaluation
- ☐ Consultation
- ☐ Other:_____

The purpose of this disclosure is for coordination of care.

Unless otherwise specifically requested, I also consentto the release of information regarding HIV/ AIDS and chemical dependency/ substance abuse. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon (i.e., information already released in reliance on a valid consent). If not earlier revoked, this consent shall expire ninety (90) days from the date of termination of services or as otherwise specified by me on:

_____without express revocation. (date, event, condition)

Client	Date
Parent/ Guardian	Date
Legally Authorized Representative/ Relationship	Date
Staff member	Date
Witness	Date

To the receiving party of this information: With respect to clients receiving chemical dependency services, this information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.