MSHC BWR MRIMAGES MDDC HCASC

Medical Records Release

Date: _____

Patient Name: _____

Patient Address: _____

Patient Date of Birth: _____ Patient Account # _____

I, _____

Hereby authorize _____

To release to _____

Contact Person: _____ Phone: _____

The following medical information from my personal medical records for services rendered

Between _____ and _____

- ❑ **Entire record**
  - ❑ **Exclude from records:**
    - ❑ **Records concerning HIV testing/treatment**
    - ❑ **Treatment for AIDS or AIDS related conditions**
    - ❑ **Drug or alcohol abuse**
    - ❑ **Drug-related conditions**
    - ❑ **Alcoholism**
    - ❑ **Psychiatric and/or psychological conditions**
- ❑ **X-ray/Diagnostic reports**
- ❑ **Laboratory results**
- ❑ **Consultation reports**
- ❑ **Most recent history and physical**
- ❑ **Other _____**

I give permission for this medical information to be used for the following reason:

_____

Please list any restrictions to the use of the medical record: _____

Patient Signature: _____Date:_____

Witness Signature: _____Date:_____

This authorization is good for one year from the date above, unless otherwise revoked.