RELEASE OF MEDICAL AND PSYCHIATRIC RECORDS

Authorization For Release Of Medical Records

_____ (name of hospital)

Patient's Name and Address: _____

Social Security Number: _____

Birth Date: _____

I authorize you to release to the persons listed below information concerning the medical and psychiatric evaluation and treatment received by the above named patient at _____ (name of hospital) during the approximate period from _____ (month & day), _____ (year), to _____ (month & day), _____ (year). This information is to be used only for the purposes of _____ (assisting in the pursuit of a legal action and obtaining psychotherapeutic and medical care).

The authorized information is to be provided only to the following persons:

_____

_____

_____

(names and addresses of persons to receive information).

This authorization is valid for _____ (number) days. I understand that I may revoke this consent at any time by sending a written notice to the _____

_____

(Director of Medical Records or the person authorized to release information or to supervise its release).

I understand that I may review the disclosed information by contacting the _____ _____ (Director of Medical Records or the person authorized to release information or to supervise its release).

_____

(Signature of Patient or Person Authorized to Consent For Patient)

_____ _____

(Relationship to Patient) (Date)