MEDICAL RECORDS RELEASE

Entity:	
Patient Name:	**Birth Date:**
Social Security No.:	**Medical Record (MMI) No.:**
Address:	**Telephone No.:**

I hereby authorize the above-referenced entity to release the medical information about me indicated below to the following recipient:

Recipient Name:	**Telephone No.:**
Address:	**Fax No.:**

Documents Needed:

- ☐ Entire Record (*no films*)
- ☐ History & Physical
- ☐ Laboratory Results
- ☐ Emergency Department Needs
- ☐ EKG Reports *(no films)*
- ☐ Pathology Reports
- ☐ Anesthesia Records
- ☐ Consultation Records
- ☐ Cardiovascular Reports
- ☐ Operative / Procedure Reports
- ☐ Discharge Summary
- ☐ Mammography Reports *(no films)*
- ☐ Other: _____

Dates of Service Needed:

☐ All ☐ Last Visit Only ☐ From: ____/____/____ To: ____/____/____

Purpose of Release:

- ☐ Continued Care *
- ☐ Legal (Attorney)
- ☐ Research
- ☐ Disability
- ☐ Dept. Children's & Family Services (DCFS)
- ☐ Insurance
- ☐ Personal
- ☐ Other: _____

* If for continued care, records needed for doctor's appointment on _____ (date) at _____ (time).

I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmissible diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Cerner or the above-referenced entity will not depend in any way on whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.

I understand that State and federal law may prohibit the Recipient from re-disclosing information provided pursuant to this Authorization, but that neither Cerner nor the above-referenced entity has any control over the Recipient and cannot, therefore, guarantee that the Recipient will not re-disclose such information. I hereby release Cerner and the above-referenced entity from any and all liability related to (i) their reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

I understand that the above-referenced entity may charge me reasonable, cost-based fees for such records of up to $1.00 per page for paper records (up to $2.00 per page for non-paper records) and an administrative fee of $1.00 for each year of records requested. The above-referenced entity will waive such fee for copies provided to another healthcare provider for continuing care or for work related health care.

By signing below, I authorize the entity checked above to release medical information about me as described above.

_____ _____
Signature of Patient Date

If the patient is (i) a minor, the patient's parent should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

_____ _____
Signature of Representative Telephone

_____ _____
Name of Representative Relationship to Patient