AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly, incomplete forms may result in a delay or denial of this request

Patient	Name	DOB
	Address	Primary Phone
	City	State Zip

Please release my records from: (Who has your records?)	Clinic or Organization:	Phone
		Fax
	Address	Dr. Name
	City	State ZIP
	☐ Check here for Hopkins Health and Wellness Center to release records	

Please Release My Records To: (Who needs your records?)	Person, Clinic, or Organization:	Phone
		Fax
	Address	Dr. Name
	City	State ZIP
	☐ Check here for Hopkins Health and Wellness Center to receive records	

Requests will not be processed if this section is not complete	These are the records I would like to Release Date Range:		
	☐ Most recent 3-5 office notes	☐ Imaging Reports	
	☐ Other		

Purpose of Release	☐ Continued care by another Provider ☐ Social Security Disability	☐ Insurance Claim ☐ Legal	☐ Personal Use ☐ Other
Method	☐ Mail	☐ Fax	☐ Pick Up

I understand the following	• All records will be released to the hospital, clinic or person above, unless specified (I do not want the following to be released:_____) • Except to the extent that action has already been taken, I understand I may revoke this authorization at any time by giving written notification to the facility identified above. • This form expires one year after I sign it, or on (exp. Date_____) • Once the records are released to the hospital, clinic, or person named above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws • To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered. • If I do not sign this form, I will still be treated.

Signature of Patient or Authorized Person_____ **Date**_____

Authorized person's authority to sign (proof required)_____ Reason patient is unable to sign_____

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