TIMBER VALLEY MEDICAL CLINIC
AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize _____
(Name of Hospital/Health Care Provider)

_____
(Address of Hospital/Health Care Provider) Ph# Fax#

to release medical information for:

_____
(Name of Patient) (Patient Date of Birth)

To: _____
(Recipient Name)

_____
(Recipient Address) Ph# Fax#

The Information will be used on my behalf for the following purpose(s):

_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

____ Laboratory reports
____ Pathology reports
____ Diagnostic imaging reports
____ Clinician office chart notes
____ Other: _____
____ Please send the entire medical record (all information) to the above named recipient.

____ MVA records only
____ W/C records only

SEPARATE, SIGNED AUTHORIZATION FORM REQUIRED FOR THE FOLLOWING:

* HIV/AIDS related records
* Genetic Testing info.
* Mental health info.
* Drug/alcohol diagnosis, treatment or referral info.

SIGNATURE: _____ DATE: _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire in 180 days from the date of signing or shall remain in effect until the date specified by the patient. Date: _____.

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