

**Community
Anticoagulation
Therapy
Clinic**

Medical Records Release Form

I hereby authorize [name of provider/address]:

To disclose the following information from the health records of:

Name: _____
Last First MI Previous Name

_____ H _____ W _____
Birth Date Social Security # Telephone #s

Address: _____
Street City State Zip

This information is to be disclosed to:

Covering the periods of healthcare (Date(s) of service):

From (date) _____ to (date) _____

For the purpose of: _____

(not required if the disclosure is requested by patient)

The following information may be released:

I understand that this will include information relating to (check and initial if applicable):

- _____ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
_____ Behavioral health service/psychiatric care
_____ Treatment for alcohol and/or drug abuse

If compensation will be received: I understand that _____ will receive compensation for its use/disclosure of the information released pursuant to this authorization. _____
patient's initials

Affirmation of Release

I give _____ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

Signature of Patient/Guardian/Legal Representative

Date Signed

Expiration date: One year from date signed or date specified: _____