Rio Grande
HOSPITAL & CLINICS
a non-profit organization

AUTHORIZATION FOR RELEASE OF INFORMATION
THIS REQUEST MUST BE FILLED OUT COMPLETELY

Patient's Name_____ **SS#**_____ **DOB**_____

Address_____

I authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal and state privacy regulations. I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Information to be released:

To:	**From:**
_____	_____
_____	_____
_____	_____
Ph:_____ Fax:_____	Ph:_____ Fax:_____

Information to be released (Please Check All That Apply):

[ ] History/Physical Exam Notes Dates: _____
[ ] Laboratory Results Dates: _____
[ ] X-Ray Reports Dates: _____
[ ] Other Diagnostic Reports Dates: _____

Yes I do [ ], or **No** I do not [ ], patient initials _____authorize the release of HIV, STD, and AIDS related information to be included with my medical records and to be sent to the person, facility or representative mentioned above on this release.

Reason/Purpose for Release (Please Check All That Apply):

[ ] Continued Patient Care
[ ] Insurance Use
[ ] Attorney / Legal Use
[ ] Disability Determination / Social Security
[ ] Personal Use
[ ] Other (Please Specify)_____

I understand that the information released is for specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 1 year after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Patient's Legal Representative **Date**
(Please attach supporting documentation for legal representative)

----------FOR OFFICE USE ONLY----------
[ ] Faxed Medical Records Release [ ] Faxed Records [ ] Mailed Records [ ] Released to Patient
Date_____ Initials_____