

**Authorization to Disclose Medical Records
Azusa Pacific University Health Center**

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Phone:

RECORDS FROM:

I authorize _____ to release a copy of
the medical record for
(Print name of Health Care Provider)

(Print Patient Name)
(Date of Birth)

RECORDS TO: (Print Name, address, and fax number of Recipient)

FOR THE PURPOSE OF:

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist (**this must be complete in order to comply with request**):

___ Records of my treatment for dates beginning _____ and ending on _____
(The patient understands that the record may be voluminous and agrees to pay all reasonable charges associated with providing this record.)

___ TB skin test results dated	___ HIV/AIDS related
___ Immunization records	___ Mental health
___ X-ray reports dated	___ Drug/Alcohol
___ diagnosis, treatment of referral	___
___ Lab reports dated	___

Other: _____

I HEREBY LIMIT THE AUTHORIZATION ACCORDING TO THE FOLLOWING:

___ This authorization is limited to the following treatment(s):

____ This authorization is limited to the following time period:

____ This authorization is limited to the following worker's compensation claim(s):

This authorization may be revoked by written notice at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period of reasonably needed to complete the request.

(Date signed)

(Signature of Patient or Person Authorized by Law)

(Date Signed)

(Witness)