RELEASE OF RECORDS AUTHORIZATION

SPA MAY RELEASE MY INFORMATION TO:

Name:	
Address:	
Phone Number:	Fax Number:

SPA MAY RECEIVE MY INFORMATION FROM:

Name:	
Address:	
Phone Number:	Fax Number:

INFORMATION TO BE RELEASED:

- ☐ The most recent 2 YEARS of pertinent information (Chart Notes, Lab Reports, Radiology, Special Tests, ect.)
- ☐ All Medical Records
- ☐ Specific Information (Please Specify):

Purpose for which information is being released (check one):

☐ Attorney ☐Insurance Provider ☐Personal ☐Other (Please Specify):_____

This Authorization Will Expire On (Date or Specific Event):_____

If no date/event is given, the authorization shall expire **90 DAYS** from the date signed. Possible copying fee required. **My Rights**: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice posted at the faculty where you information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, at which time it may no longer be protected under Privacy laws.

PATIENT NAME (PRINT):_____ **DOB:**_____

PATIENT/ GUARDIAN SIGNATURE:_____ **DATE:**_____