CHADWICK MEDICAL ASSOCIATES, P.C.
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to Chadwick. There may be a processing fee associated with this request.

AS YOU COMPLETE EACH STEP ON THE FORM, PLEASE MAKE A CHECK MARK IN THE BOX PROVIDED ON THE LEFT.

Step 1 Completed ☐

STEP 1: Information about you: **PLEASE PRINT!**

PATIENT NAME: _____ DATE OF BIRTH: _____
Last First

ADDRESS: _____
Street City State Zip

Step 2 Completed ☐

STEP 2: Who has the records now? **PLEASE PRINT!**

I hereby authorize: _____ M.D./D.M.D. (Circle one)

Physician's Address _____

_____

Step 3 Completed ☐

STEP 3: To whom do you wish to release your records? **PLEASE PRINT!**

To release the following information: Please specify:

☐ ALL RECORDS OR

☐ Dates of Treatment: _____ TO _____ OTHER: _____

TO: _____M.D./D.M.D. (Circle one)

_____

_____

Step 4 Completed ☐

STEP 4: Your signature:

This authorization is valid from 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

_____
Patient's Signature

_____ _____
Witness Signature Parent/Guardian's Signature

Step 5 Completed ☐

STEP 5: Release for Sensitive Information:

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION I AGREE TO ITS RELEASE

_____ _____
Signature of Patient or Legal Guardian Date

Step 6 Completed ☐

STEP 6: Release of HIV Information:

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION

_____ _____
Signature of Patient or Legal Guardian Date