

**Hawthorne Medical Associates**  
Medical Record Release

There may be a charge for record copies.

I hereby authorize the use or disclosure of my identifiable health information as described below.

**NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security number: \_\_\_\_\_

**RELEASE FROM:** The facility/practice/individual listed below is authorized to release the requested information:

Facility/Practice Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Facility/Practice Address: \_\_\_\_\_ FAX #: \_\_\_\_\_

**PURPOSE OF RELEASE:**  On-going communication  Copy of Record  Legal or Insurance Review  
 Other \_\_\_\_\_

**CHECK SPECIFIC INFORMATION TO BE RELEASED:**

All records & details  Office Notes  Lab results  Other test results

Other (please specify) \_\_\_\_\_

Dates of Service: From: \_\_\_\_\_ to \_\_\_\_\_

*I understand that the information in my medical record may include information related to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV) and any other statutory protected diseases.*

**RELEASE TO:** This information may be released to and used by the following individuals/organizations.

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ FAX #: \_\_\_\_\_

**PATIENT'S RIGHTS AND SIGNATURE:**

- I understand that I have a right to revoke this authorization at any time except to the extent that action has previously been taken in reliance thereof.
- I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.
- I understand that copies of the records will be released, not originals, and that they may be faxed if appropriate.
- A photocopy and/or facsimile (fax) legally serves as the original.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If Authorized Representative, please indicate relationship to patient:  Spouse  Parent  Guardian  Executor of Estate  POA

**MINOR'S SIGNATURE:** If the information is related to the treatment of pregnancy, drug and/or alcohol abuse, venereal disease or emotional disturbance for a patient under the age of 18, the patient must also sign this authorization.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

HMA Signature: \_\_\_\_\_  FAXED  MAILED Date: \_\_\_\_\_