MyMedicalHistoryOnline.com

Medical record and history organization for safer patient care.™

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize that the medical record information regarding:

Patient Name: Last First M.I.

Street Address: City State

Phone: Date of Birth:

Social Security #: Medical Record # (if known):

be forwarded from:

Hospital, Institution or Medical Provider:

Street Address City State

Fax the requested Records to: **(888) 481-4756** MyMedicalHistoryOnline secure Fax

This information is to be used to further streamline and organize my medical care, and enable me to provide my caregivers with the most complete, and up-to-date information possible.
Information that I would like to organize includes data from within the last 18 months, including all checked items below:

X-ray results
CT scan readings
MRI readings
Ultrasound interpretations
Recent laboratory test results
Blood tests
Serum chemistries

12-lead EKG tracing
Urinalyses
Major operative reports
Holter monitor summaries
Pulmonary function tests
Diagnostic procedure reports
Recent hospital discharge summaries
Other

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **INITIALS** in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THE AUTHORIZATION **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

I have read this authorization and I understand it.

Patient Signature:____ Date:____________________

Authorization if patient is unable to sign:________________________________

Relationship to patient if unable to sign:________________________________

Mail or Fax this completed form to your Hospital, Medical Group, Institution or Doctor –more than one form may be needed