

Elite Medicine and Aesthetic Institute

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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

**INFORMATION TO BE RELEASED OR ACCESSED:**

<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> ER Records
<input type="checkbox"/> Last Lab Report	<input type="checkbox"/> Hospital Records
<input type="checkbox"/> Last Wellness Visit	<input type="checkbox"/> X-Ray Reports/Images

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

**TO:**

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

Phone/Fax Number

Address (Street, City, State and ZIP)

**FROM:**

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

Phone/Fax Number

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one year from the date of my signature, unless I revoke the authorization prior to that time.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_