Authorization for Release of Information
Midwest Immunology Clinic and Midwest Infusion Center

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

I hereby authorize (provider sending records) _____

to release information from my medical record, as indicated below, to:

Name (provider receiving records): _____

Address: _____

Phone: _____ **Fax:** _____

INFORMATION TO BE RELEASED

Circle one or all that apply: History/physical exam, Progress notes, Lab reports, X-ray reports

List Other:

_____
_____
_____

From-To Date Of Service:

_____
_____
_____

I specifically authorize release of information relating to:
_____ Substance Abuse _____ Mental Health _____ HIV related information
Signature: _____

Purpose Of Disclosure (circle which applies)

Changing Of Physicians – Consultation/Second Opinion, Continuing Care, Legal, School Insurance, Workers Compensation, Other (please specify) _____

1. I understand that this authorization will expire 1 year after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy Regulations.
4. I understand that I may see and/or receive a copy of this form upon my request.
5. I understand that Midwest Immunology Clinic and Infusion Center is not allowed to release any medical information that has been obtained from another medical provider or facility.

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____