the ODC
OUTPATIENT
DIAGNOSTIC CENTER

General Medical Records Release

Authorization for the Use, Disclosure and Receipt of Protected Health Information

Patient Name: _____ DOB: _____ MRN# _____

Gender: ◯ Male or ◯ Female **Phone Number: _____**

I request and authorize:

_____

_____

_____

To release my medical information to:

_____

_____

_____

I authorize the following information to be released / disclosed:

◯ All Records
◯ Laboratory / pathology reports
◯ Clinical Office Notes
◯ Billing Records
◯ Other: _____

◯ X-Ray Records
◯ MRI / CT Records
◯ Mammogram Records
◯ Ultrasound Records

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing disclosure of this information.

These records are for the services provided on the following date(s): _____

For the purpose(s) of:
◯ At the request of the patient or legal/personal representative
◯ For my health care
◯ Other purposes: _____

Unless revoked, this authorization is valid for one year from the signature date below, or for the following time period:
Beginning date: _____ to Ending (expiration) date: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; received payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of Patient / Representative: _____ Date: _____

Printed Name of Patient / Representative: _____

Representative's Authority to Sign for Patient: _____