THE DOCTORS TREATMENT CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to The Doctors Treatment Center upon request in person or by mail to the address specified at the time of the request.

Patient Name: _____ DOB: _____

Provider Name: _____

Provider Address: _____

_____

RECORDS AUTHORIZED TO BE RELEASED:

__ Admission history and physical

__Discharge summary

__ Complete hospital chart

__ Office notes

__ Outpatient records

__ Psychiatric and other mental health records

__ Lab Reports

__ Radiological images

__ Consultation notes or reports

__ Complaints or grievances filed, with responses/dispositions

__ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)

__ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part Of my individual medical record, but which contain information relating to me. (These records should be redacted to protect information pertaining to other patients.)

__ Other (Specify): _____

Extent or Nature of records to be released: (ex, specific hospitalization or visit) _____

This information will be used for the purpose of:

__ Investigating an allegation of abuse

__ Providing advocacy services

__ Other activities at the request of the individual

__ Verifying my eligibility for services offered by the

__ Legal Representation

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider or to the , but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.

Federal privacy regulations will no longer apply to the information disclosed, and that may re-disclose the information.

I am entitled to receive a copy of this authorization.

A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Representative Signature: _____ Date: _____

Name of Representative (Print): _____

Relationship to Patient: _____