



Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

I hereby authorize Solantic and its representatives to release medical information about me to the following recipient:

Recipient Name _____ Telephone: _____

Address: _____

Documents Needed:

- Entire Record
 Radiology Reports

- Progress Notes
 Other _____

Dates of Service Needed:

- All
 Last visit only
 Records dated from ___/___/___ to ___/___/___

Purpose of Release:

- Continued Care
 Legal

- Research
 Disability

- Insurance
 Personal
 Other _____

I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this authorization. I understand that I am under no obligation to sign this authorization, and that my ability to obtain services from Solantic will not depend in any way on whether I sign this authorization. I understand that I have a right to receive a copy of this Authorization. I understand that Solantic may charge me or the Recipient a reasonable, cost-based fee for such records.

I understand that state and federal law may prohibit the recipient from re-disclosing information provided pursuant to this Authorization, but that Solantic has no control over the recipient and cannot guarantee that the recipient will not re-disclose the information. I hereby release Solantic from any and all liability related to (i) its reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

By signing below, I authorize Solantic and its representatives to release the information about me described above.

Signature of Patient

Date

If the patient is (i) a minor, the patient's parent or legal guardian should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

Signature of Representative

Date

Name of Representative