MEDICAL RECORD	AUTHORIZATION FOR DISCLOSURE OF INFORMATION

This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. For authorization to disclose alcohol or drug abuse patient information, see 42 CFR 2 and AR 600-85.

(Pursuant to the Privacy Act of 1974, Public Law 93-579)

PHYSICIAN OR MEDICAL TREATMENT FACILITY AUTHORIZED TO RELEASE INFORMATION	It is understood that this authorization may be revoked at any time, if requested in writing, except to the extent that action will have already been taken.

PATIENT DATA

NAME *(Last, First, MI)*	DATE OF BIRTH	SOCIAL SECURITY/IDENTIFICATION NUMBER
PERIOD OF TREATMENT *(Month, Day, Year)*	TYPE OF TREATMENT ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

RESTRICTIONS ON INFORMATION *(Specify)*

USE OF MEDICAL INFORMATION

☐ FURTHER MEDICAL CARE ☐ INSURANCE CLAIM(S) ☐ ATTORNEY ☐ DISABILITY DETERMINATION

☐ OTHER *(Specify)*

INFORMATION DESTINATION

INDIVIDUAL OR ORGANIZATION TO WHOM INFORMATION SHOULD BE RELEASED *(Name and Address)*

(ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE)

RELEASE AUTHORIZATION

I hereby request and authorize the named physician/medical treatment facility to release the medical information described above to the named individual/organization indicated.	DATE
SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT

IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE