

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Facility Name: \_\_\_\_\_  
 (If requesting from multiple locations affiliated with Monarch Health Care a release form for each location will be required)

RE: (Patient's Name) FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

Other names used: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Social Security Number (last 4 digits): \_\_\_\_\_

I authorized the above named party to release to:

\_\_\_\_\_  
 Representative, Company, Attorney, etc.

\_\_\_\_\_  
 Address City State Zip

Any and all medical records, including reports involving alcohol, drug abuse, and psychiatric treatment or recovery (if applicable) from \_\_\_\_\_ to \_\_\_\_\_  
 Date Date

OR selected medical records, including reports involving alcohol, drug abuse, or psychiatric treatment or recovery (if applicable) from \_\_\_\_\_ to \_\_\_\_\_  
 Date Date

Concerning \_\_\_\_\_  
 Specific diagnosis or treatment, auto accident, etc. (if known)

Use the checklist below to specify category(s) necessary for copying:

- |  |   |
|--|---|
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Progress Notes         |
| <input type="checkbox"/> Clinical Summary        | <input type="checkbox"/> Physicians             |
| <input type="checkbox"/> Operative Reports       | <input type="checkbox"/> Nurses                 |
| <input type="checkbox"/> Pathology Reports       | <input type="checkbox"/> Other                  |
| <input type="checkbox"/> Consultation Reports    | <input type="checkbox"/> Outpatient information |
| <input type="checkbox"/> X-ray Reports           | <input type="checkbox"/> Other (Please specify) |

FORMAT FOR RECORDS (circle) DIGITAL OR PAPER

These records are required for the purpose(s) of \_\_\_\_\_

Permission is given to forward this information by photocopy or by facsimile (fax), or other electronic device.

This authorization will remain in effect a maximum of one year from the date of signature and may be canceled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

\_\_\_\_\_  
 Signature of Patient/Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Witness (optional)

Reason Patient is Unable to Sign: \_\_\_\_\_