Authorization to Obtain/ Release Medical Information

Patient Information
Patient Name: ______________________________
DOB: _________________
Address: ____
City: _______________________________________ State: ____________ Zip:_________________
Daytime Telephone: _______________

I hereby authorize Dr. Karen Tyson to obtain information from:

Name of Practitioner: ____
Name of Clinic: ______________________________
Phone/ Fax: _______________________________
Address: ____
City: _____________________________ State: _______________________ Zip: _____________

Information to be released or obtained as follows: (please check one)
All: ___________________
Limited to: ____ (specify)

Purpose of disclosure: (please check one)

At patients/guardian's request: ______ Changing physicians: _____
School: _____Legal: _____Consultation: _____ Other: ______

1. I understand that this authorization will expire one year after I have signed the form, or other timeframe as specified: _______________________________
2. I understand that I may revoke this authorization at any time by notifying the Dr. Karen Tyson in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that I am not required to sign this form to receive treatment or payment for my care.

4. I understand that there is a fee for a copy of my medical record.
5. I understand that the request could take at least two weeks to process.
6. I understand that information to be released or obtained may include mental health, substance abuse, or HIV/AIDS-related information, except as indicated below:

NO Mental Health _________ NO Substance Abuse __________ NO HIV/AIDS_______ _______

____ ________________

Signature of patient/parent/legal guardian/ authorized person Date