reboot center
FOR INNOVATIVE MEDICINE™

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient name: _____ Date of birth: ____ /____ /_____

Patient address: _____ Today's date: ____ /____ /_____

Information to be released by:
Organization/Person: _____ Phone: _____
Address: _____ Fax: _____

Information to be released to:
Organization/Person: _____ Phone: _____
Address: _____ Fax: _____

Health information to be released: **For the following dates**: _____
__All medical records (incl. 3 years of chart notes, recent labs/pathology/imaging reports)
__Lab reports __X-ray or other diagnostic imaging reports
__Office visit notes __Other: _____

Purpose of need for disclosure (*check appropriate categories*):
__Transfer of medical care __Personal __Vocational rehabilitation evaluation
__Continuing care __Disability __Insurance
__Other (please explain): _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. I hereby specifically authorize Reboot Center to release all information or medical records relating to such diagnosis, testing, or treatment, unless this exclusion is indicated here: _____.

Expiration:
This Authorization expires on _____(date). Authorization will expire in 90 days if not otherwise specified.

Minors ages 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Signature:
I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand that the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits.

Fees for records:
Reboot Center may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of health information.

Patient signature: _____ **Date:** _____

Parent or Legal Guardian signature: _____ **Date:** _____

Relationship to patient, if other than patient: _____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)
You are entitled to a copy of this signed Authorization.