

**Authorization for Release of General Information**  
(excludes Mental Health and Developmental Disability information)

\_\_\_\_\_  
Patient Name – Please Print

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City / State / Zip

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Phone

I hereby authorize:

To disclose to:

\_\_\_\_\_  
Name of Individual / Organization / Class of Persons

OSFMG

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City / State / Zip

The following information (check all boxes that apply):

NOTE: The release will not include Genetic or HIV/AIDS information unless the specific box is checked.

Complete Chart

Genetic Information

HIV/AIDS Information

Circle those that apply: Labs   Radiology   Consult Report   Immunizations

Records regarding \_\_\_\_\_ (specific event)    Other: \_\_\_\_\_

Concerning treatment from: \_\_\_\_\_ to: \_\_\_\_\_  
Date Date

This disclosure is made for the purpose of: \_\_\_\_\_  
Please Print (i.e. At the request of the patient)

- I have the right to inspect and obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that this authorization is voluntary. I understand that the person(s) or organization(s) authorized to make requested use and / or disclosure may not condition the provision of treatment on the provision of an authorization.
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the office authorized above to make the release. I understand the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on the following date or event: \_\_\_\_\_. If I do not specify an expiration date or event, this authorization will expire in 12 months from the signature date.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name and Relationship (Please Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Request Completed on (date)

\_\_\_\_\_  
Initials of Employee Completing Request