Authorization for Release of Information
Midwest Immunology Clinic and Midwest Infusion Center

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home:_____ Cell: _____ Work: _____

I hereby authorize _____ to release the following
(Provider sending records)
information from my medical record, as indicated below, to:

Name (Provider receiving records): _____

Address: _____

Phone: _____ Fax: _____

Information To Be Released:		From-To Date Of Service:	I specifically authorize release of information relating to:
History/physical exam	____	_____	_____ Substance Abuse
Progress notes	____	_____	_____ Mental Health
Lab reports	____	_____	_____ HIV related information
X-ray reports	____	_____	Signature: _____
Other	____	_____	

Purpose Of Disclosure: (circle which applies)
Changing of physicians – Consultation/second opinion – Continuing medical care – Legal – School insurance – Workers compensation – Other (please specify) _____

1. I understand that this authorization will expire 1 year after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization 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 information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy Regulations.
4. I understand that I may see and/or receive a copy of this form upon my request.
5. I understand that Midwest Immunology Clinic and Infusion Center is not allowed to release any medical information that has been obtained from another medical provider or facility.

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____