## AUTHORIZATION FOR RELEASE OF INFORMATION

**PATIENT NAME**: Last_____First_____MI_____ DATE OF BIRTH: _____

ADDRESS: _____CITY: _____STATE_____ZIP_____

HOME PHONE_____CELL PHONE: _____

I hereby authorize (PREVIOUS Doctor or Facility) _____Phone _____

To release information from my medical record as indicated below to:

**MILFORD MEDICAL ASSOCIATES**
**611 FEDERAL STREET, SUITE 2**
**MILTON, DE 19968**

**PHONE: 302-329-9616**
**FAX: 302-329-9801**

**INFORMATION TO BE RELEASED:**
HISTORY AND PHYSICAL EXAM: _____DATES _____
PROGRESS NOTES: _____ DATES _____
LAB REPORTS: _____DATES _____
DX IMAGING REPORTS: _____ DATES_____
OTHER: _____ DATES_____

I specifically authorize the release of information relating to:
- Substance abuse (including alcohol /drug abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

X _____Date_____
Signature of Patient or Legal Guardian

**PURPOSE OF DISCLOSURE**: ___CHANGING PHYSICIANS ___ CONSULTATION / SECOND OPINION ___CONT CARE
___LEGAL ___SCHOOL ___INSURANCE ____WORKER'S COMPENSATION
___ OTHER (PLEASE SPECIFY)_____

1. I understand that this authorization will expire 90 days 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 if I am being requested to release this information by Milford Medical Associates for the purpose of:_____that
   - By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   - I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   - I have been informed that Milford Medical Associates ___will / ___will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with DELAWARE statute, I will not pay a fee for this service.

_____or _____**Date_____**
**SIGNATURE OF PATIENT** **PARENT / LEGAL GUARDIAN / AUTHORIZED PERSON**

**RECORDS WERE RECEIVED BY_____DATE_____RELATIONSHIP TO PATIENT_____**
**SIGNATURE OF WITNESS**_____