Colleen Campbell, M.D.

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Authorization to Release Medical Information

I, **(patient name)**_____,D.O.B._____,authorize

Name & Address of Organization:_____

Ph:_____Fax:_____

To **Release to** (Name & Contact Information) : **DR. CAMPBELL**

Dates of Service:
From:_____To:_____

Information to be released: (check which one): _____Complete Record

_____Medication List

_____Diagnostic Studies

_____Labs

_____(ECG)

_____Consultation/Progress Notes

_____Other (please specify)_____

Purpose of Release (circle one) : Continued Treatment, Personal, Payment of Insurance Claim, Legal

Other & Explain_____

This authorization will expire either on the following date, event, condition:_____

or one year from signed consent.

I understand that a reasonable fee may be charged for duplication of records and the estimated costs may be obtained upon request prior to duplication.

Signature of Patient _____Ph#:_____

or Legally Authorized
Representative_____Ph#:_____

Date:_____

Circle any Special Authorization you want released : Alcohol, Drug Abuse, Mental Health, Genetic testing, STD, HIV/AIDS

Note that a general authorization for release of medical records does not include those for alcohol, drug abuse, mental health, genetic testing, sexual transmitted disease, HIV/AIDS. This information is protected by federal confidentiality rules (42 CFR part 2). By signing this portion of the written consent, you are authorizing Dr. Campbell to obtain, or share, this information. Federal rules restrict use of this disclosure to criminally investigate or prosecute any patient with history of alcohol or drug abuse.

Patient Signature for Special Authorization: _____***Date:***_____