Sample Authorization to Release Medical Records

Dear Dr. _____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____ Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s)

_____

_____ Other. Specify:
_____

_____ Confer with other person orally about information in my medical record

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

Initial _____Date _____

to the following person(s):

_____
Name

_____
Street

_____
City State ZIP

The reasons or purposes for this release of information are:

_____

_____

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed:_____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

This sample has been taken from TMA's *Transitions, Legal Considerations in Closing or Selling a Medical Practice*. This publication offers guidance from TMA's Office of General Counsel on the host of areas a physician must consider when making a practice change. It is available to TMA Members for $37.89 (includes tax). Order *Transitions*.