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**Request and Authorization to Release, Use and /or Share Medical Information**

New Federal Privacy Laws require us to obtain patients/parent/legal guardian permission to release, use and/or share patient medical information.

I give my authorization/permission for Dr. Warmuth's office to obtain/release/use and/or share the medical information described below. I understand that this permission is voluntary. I also understand that once the information is released, used and or shared, the person or organization may share it again. If this happens, the information may no longer be protected under applicable privacy laws. I understand what type of information is going to be released, used and/or shared and how it is going to be done.

**Patient's Name** \_\_\_\_\_  
**Patient's address** \_\_\_\_\_  
**City, State, Zip** \_\_\_\_\_  
**Patient's Date of Birth** \_\_\_\_\_

Please indicate the records below that you would like to be released, used and/or shared.

Biopsy results \_\_\_\_\_  
Blood work results \_\_\_\_\_  
Office notes \_\_\_\_\_  
Other \_\_\_\_\_

If the medical records contains any of the following information, may we release, use and/or share it? If you answered yes, please initial next to each type of information listed here:

Drug and/or alcohol testing \_\_\_\_\_  
HIV information \_\_\_\_\_  
Mental Health Information \_\_\_\_\_

You may give my information to:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Fax \_\_\_\_\_

**What is the reason for releasing using and/or sharing this information?** The information will be released, used and/or shared for these specific reasons:

\_\_\_\_\_  
\_\_\_\_\_

Time Limit: What is the time limit for this permission? Please note, the date you give us cannot be more than 90 days from now. \_\_\_\_\_

I understand that I may revoke (withdraw) my permission at any time. If I wish to withdraw my permission, I must put this request in writing.

I understand that if I send a letter withdrawing my permission, that letter cannot bring back any information that was already released, used and/or shared. I also understand that it will take time for Dr. Warmuth's office to receive and process my request.

Signature of Patient/Parent /Legal Guardian \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_