



Michele O'Fallon, M.D. Laurie Montano, M.D.
Board Certified Internal Medicine & Pediatric Specialists

1) PATIENT INFORMATION:

Name _____ Address _____ City _____ State _____ Zip _____
Date of Birth _____ () Daytime Phone _____ Previous Name _____

2) AUTHORIZES:

Name of Health Care Provider / Plan / Other _____
Address _____

3) TO DISCLOSE TO:

Self, Delivery Options: Pick up: View on Site Mail to address above
 To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)
Send to: _____
Name of Health Care Provider / Plan / Other _____

Address _____ Or Health Care Provider FAX # _____

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____
information from the past two (2) years will be disclosed. (month/year) (month/year) If left blank, only

5) INFORMATION TO BE DISCLOSED:

All medical records related to (specify condition, treatment, etc.): _____
 All billing records related to (specify condition, treatment, etc.): _____
 Radiology films/images (specify test): _____
 Specific records/information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
 Alcohol/Drug Abuse HIV Test Results Mental Health / Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) PURPOSE (Check all that apply - copy fees may apply) Further Medical Care Legal Investigation /Action
 Insurance Eligibility/Benefits Personal (at my request) Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ DATE: _____
If signed by a person other than the patient, complete the following:

- Individual is: a minor legally incompetent or incapacitated deceased
- Legal authority: parent* legal guardian next of kin / executor of deceased activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:

Signature/ID verified Yes No Completed by: _____ # of pages released _____
Name / Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION