Authorization for Release/Use of Medical Information

Patient's Name:
_____
Address:
_____
City/State/Zip:
_____
Phone: _____ Date of Birth: _____

Purpose for this request:

To enable my parent(s) and/or my primary physician, named below, to discuss my medical condition freely with health care providers and insurance companies abroad to help me in medical decision-making and management of my health while I am outside of the U.S.

This Authorization allows doctors, nurses, clinicians, medical billers, medical insurance personal, and hospital administrators (add/include certified counselors/psychotherapists if desired) to:

*Send copies of my medical record and
*To discuss my diagnosis and recommended treatment with the provider/person/ below:

Name of Provider/Person/Facility: (put in parent or doctor's name here)

Name:
_____
Address:
_____
City/State/Zip:
_____
Phone:
_____
Fax:
_____
Phone: _____ Fax: _____

Type of Records/Information Requested: (Circle ALL that apply)

Inpatient/Outpatient (place, date, time of service, if applicable)
Discharge Instructions
Summary of Treatment
Medication & Problem list
History & Physical
Office Notes & Consult Notes
Tests & Reports
Labs & Imaging

I understand that this Authorization may include disclosures of information relating to alcohol and drug abuse and mental health treatment (except psychotherapy notes) if I place my initials on the appropriate line below.
Alcohol/drug treatment

_____
Mental Health Information

_____

_____
Authorization Valid For: INSERT DATES YOU WILL BE ABROAD
This authorization applies to the records of the treatment received on or prior to the date of this authorization expires.

I Understand That:
My right to healthcare treatment is not conditioned on this authorization. I may cancel this authorization at any time by submitting a written request to the providers of my care, except where a disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed by the recipient

There may be a charge for the requested records. The medical records requested above may be faxed or emailed in cases of medical necessity.

Signature of Patient/Representative: _____

_____
Date: ____/____/___

Have form notarized here: