Jennifer Stalkup, M.D.
AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ who resides at _____

in the city of _____ in the state of _____ hereby authorizes:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: _____

City, St., Zip: _____

to disclose the following specific medical information by ___ mail or ___ fax or ____ e-mail to:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER, HEALTHPLAN, THIRD-PARTY ADMIN OR OTHER PAYOR)

Address: _____

City, St., Zip: _____

from the Health Records of:

Name: _____
(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)

Address: _____

City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments

_____ Records of visits (all visits)

_____ Record of visit for a specific date or dates. Specific dates include or are limited to:

_____ Copies of records or reports provided to the above-named (i.e., hospital, lab, clinic, etc.)

_____ Progress Notes

_____ Photographs, videotapes, digital, or other images

_____ Discharge Summary

_____ History and Physical Examination

_____ Consultation Reports

_____ All of the above

_____ Other (Must be specific) _____

_____ Mental Health and/or alcohol and drug abuse treatment

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information

_____ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner, if noted below.

4. **DR. JENNIFER STALKUP**, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

(PATIENT'S NAME PRINTED) DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) REVOCATION DATE (IF OTHER THAN 60 DAYS FROM DATE ABOVE)

_____

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

_____ _____

WITNESS DATE