

## AUTHORIZATION TO OBTAIN MEDICAL RECORDS

To whom it may concern:

I, the undersigned, authorize you to provide any and all information in your possession relative to my physical condition, including but not limited to, reports, evaluations, x-rays, treatment records, treatment reports, treatment evaluation, diagnosis, prescriptions, progress notes, order sheets, admission forms, laboratory reports, nurse's reports, incident reports, consultation reports, thermographic results, results of magnetic resonance imaging or any other medical or hospital records which may be requested to **GAL/AMC**.

I further authorize that this release include all psychiatric and/or psychological information except for psychotherapy notes which must be requested by separate authorization. I am willing that a dated and signed photocopy of this authorization will have the same force and effect as the original. Be advised that this authorization is limited neither in time nor medical subject area.

The purpose of this authorization and request is to permit **GAL/AMC**, to obtain all medical information pertaining to my physical or mental condition. This authorization expires 3 years from the date of the signature.

I have the right to revoke this authorization in a signed writing to the health care provider or to **GAL/AMC**, except to the extent that the provider has already complied with the request in reliance on this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and will no longer be protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act.

Finally, this authorization acts as revocation of any and all authorizations which I may have signed prior to the effective date hereof, and as a result, any other authorization in your possession is hereby revoked and canceled.

Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_