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AUTHORIZATION FOR OBTAINING PERSONAL RECORDS FROM OUR OFFICE

I, _____ of _____
(Name) (Address)

_____
(City, State) (Zip code)

Date of Birth: _____ Social Security Number: _____

Authorize: **Dr Murko M.D. P.A.**

To release my personal records by fax, email, or mail.

I, (as stated above) do hereby authorize any health care provider or entity who has provided health care to me, or my dependent, to provide the Clinician designated above , or its authorized representatives, any and all information relevant to me, all treatment and billing records, including, but not limited to patient records, medical charts, test results, billing and payment records, insurance correspondence, evaluations, x-rays or other diagnostic tools, prescriptions, progress notes, history and physicals, order sheets, admission forms, laboratory reports, hospital records, incident reports and consultation records, for the purpose of my, or my dependent's, continuing care.

Further, if applicable, I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

I hereby authorize Dr. Murko to release / obtain copies of Psychiatric, Drug and Alcohol, HIV, and Medical information from the health care record pertaining to hospitalization / treatment for ___All Dates___ (specify dates or treatment) by mail, courier, telephone conversation, electronic mail, or facsimile transmittal to or from .

These records are required for the purpose of: (check at least one)
☒ Providing information to health care providers ☐ Legal Purposes ☐ Social Security / Disability
☐ Other: (specify) _____

Please initial the following:

_____ I understand that my healthcare and payment for health care will not be affected if I do not sign this form, and I am entitled to a copy of this from (upon request) after I sign it.

_____ I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that this authorization expires exactly three years from the date of my signature below.

_____ I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written and dated communication to the Medical Records Department at the office of Dr. Murko.

This information has been disclosed from confidential records protected by state and federal laws; those that are more stringent will apply. Any further disclosure of this information is not permitted without specific authorization to do so.

I certify that I have read and fully understand the content of this page.

Signature of Patient: _____ Date: _____

Signature of Parent / Guardian _____ Date: _____