RECOMMENDED SAMPLE
Authorization or Refusal to Release Medical Records for Out-of-Network Family Planning Services

Name: _____
Last First Middle Initial

Address: _____
Street

_____
City State Zip

Date of Birth: _____ Client Record No.: _____

CONSENT TO RELEASE MEDICAL RECORDS:

I hereby REQUEST AND AUTHORIZE _____ to release
(name of clinic)

From/sent to (circle one or both) _____ any information and
(name of managed care plan)

Records related to the diagnosis and treatment of me by you from _____ to _____
(date) (date)

Date: _____ Patient's Signature: _____

Date: _____ Patient's Signature: _____

REFUSAL TO RELEASE MEDICAL RECORDS:

A. I hereby request that you <u>DO NOT:</u>

❑ Release to my plan any information and/or medical records related to diagnosis and treatment provided to me by your clinic.

B. I hereby request that you <u>DO NOT</u>

❑ Submit a bill to my plan for processing and payment.

Date: _____ Patient's Signature: _____

Date: _____ Patient's Signature: _____

Instructions:

1. Use to obtain consent to release and/or send medical records – Consent Section	*Keep original in record.*
2. Use to document absolute confidentiality – Item A & B	*Keep original in record.*
3. Use to document medical record refusal – Item A only	*Keep original in record.*