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 DO NOT:

❑ 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 DO NOT

❑ 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.*