Michael F. Cantwell MD, MPH
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Authorization for Disclosure or to Obtain Health Information

Patient Name: _____ Date of Birth: _____ Due date if applicable: _____

1. Please check one or both of the following:
____ I hereby authorize the office of Dr. Cantwell to obtain the following information from health records of:
____ I hereby authorize the office of Dr. Cantwell to disclose the following information from health records of:

2. Disclose or obtained information from/to:

Name: _____Address:_____

Phone: _____ Fax:_____

For the purpose of: _____

Covering the Dates: _____ to _____

3. Information to be disclosed:

___complete health record(s)
___discharge summary
___history & physical examination _
___progress notes
___ Consultation reports
___ Laboratory tests
____X-ray Reports
____pictures/videotapes/digital/other images
____other (please specify below)
_____

I understand that this will include information relating to (check if applicable):

___Acquired Immunodeficiency Syndrome (AIDS)
___Human Immunodeficiency Syndrome (HIV)
____behavioral health service/psychiatric care
____treatment for alcohol and/or drug abuse

4. When disclosing records a fee of $20.00 must be paid for less than 30 pages and $40.00 for any records over 30 pages. Only testing ordered by Dr. Cantwell will be released.

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or Condition: _____

6. Dr. Cantwell and his employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein signed:

Patient/or Legal Representative: _____ Date: _____

Relationship to Patient: _____ Date: _____

Signature of Witness: _____ Date: _____