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

Patient Name: _____ Date of Birth: _____

1. Action to be taken:
   _____ Records to be sent Due date if applicable: _____
   _____ Consult appointment (between Dr. Cantwell & the person(s) in section 3) Due date if applicable: _____

2. 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:

3. Disclose or obtained information from/to:
   Name: _____Address:_____
   Phone: _____ Fax:_____
   For the purpose of: _____
   Covering the Dates: _____ to _____

4. Information to be disclosed:

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

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

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

5. 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. For Consult appointments you will be charged one half your normal hourly rates. We will automatically charge your credit card on file.

6. 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: _____

7. 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: _____