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ASP Internal Use Only: **[H]** **[R]** **[F E]**

MEDICAL RECORDS RELEASE AUTHORIZATION

ALTERNATIVE SOLUTIONS PLUS WILL NOT ASSUME ANY RESPONSIBILITY FOR THE COST OF PROVIDING THESE RECORDS TO US. ANY AND ALL COSTS ARE THE RESPONSIBILITY OF THE PATIENT SIGNING THIS RELEASE FORM.

Date: ____/____/____

Patient Name: _____

DOB: _____

Patient Signature: ****** **X**_____

I HEREBY AUTHORIZE MY CLINIC AND/OR PHYSICIAN LISTED BELOW:

Name: _____

C/O: _____

City/State: _____ / _____

Office Number : _____

Fax Number: _____

To release a copy of ALL my CURRENT & PAST medical records held by you or under your supervision. Please FAX or MAIL a copy of them to ALTERNATIVE SOLUTIONS PLUS. (No Film Or X Rays)... This written request for records is good for the next 180 days from the date posted above.

I understand that:

- ***I may inspect or copy the protected health information to be used or disclosed.***
- ***I may revoke this authorization in writing by contacting your office at the address above.***
- ***Information used or disclosed pursuant to the authorization may be subject to re-disclosure by recipient and no longer be protected by HIPAA. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request.***