

BP-A621_Consent to Release Medical Information

CONSENT TO RELEASE MEDICAL INFORMATION

**U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS**

Name of Inmate	Register Number	Date of Birth	Social Security Number

I, _____

hereby authorize _____

to disclose and / or deliver to :

A copy of and/or information from my medical file pertaining to my evaluation and treatment received

From _____ To _____

This is to include:

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Narrative Summary |
| <input type="checkbox"/> X - Ray Report | <input type="checkbox"/> Consultation | <input type="checkbox"/> Actual Slides | <input type="checkbox"/> Actual Films | <input type="checkbox"/> Entire Medical Records |
| <input type="checkbox"/> Other | _____ | | | |

I understand the information is to be used for (specific nature, reason for release of information):

I understand that I may revoke this consent at any time by sending a written notice to the Supervisor of Medical Records. I Understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

This authorization will automatically expire six months from the date of signature.

Signature of Patient	Date	Staff Witness

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.
Must sign below, to Release Protected Information.**

I specifically authorize the release of data and information relating to:

- | | | |
|---|---|--|
| <input type="checkbox"/> 1. Substance Abuse | <input type="checkbox"/> 2. Mental Health | <input type="checkbox"/> HIV Related Information |
|---|---|--|

Signature Date