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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____
Last First MI
Address _____ Phone Number (____) _____
DOB ____ - ____ - ____ Social Security # _____ - ____ - _____

I hereby authorize: _____
Healthcare Provider or Facility

Street Address

City State Zip Code

Phone Number Fax Number.

To provide information to: _____
Person, Healthcare Provider or Facility

Street Address

City State Zip Code

Phone Number Fax Number

The following information: _____ Complete Medical History _____ Radiology and/or Lab Reports
_____ Partial Medical History From _____ to _____
_____ Emergency Room Reports _____ Other (Specify) _____

The sole purpose of this disclosure is (circle):
Treatment/Continuity of Care Personal Insurance-Health, Life
Personal Injury Claim Auto Accident Claim

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, HIV test results, and AIDS, Sexually Transmitted Diseases, alcohol and/or drug dependence abuse. This authorization expires ONE YEAR from the date of signature. This authorization may be revoked by written notice at any time prior to this date. I understand that any information released prior to the revocation cannot be retrieved and FAMILY PRACTICE ASSOCIATES, INC. will not be held responsible for such disclosure.

Patient Signature Date

Parent or Legal Representative Signature Date

Witness Signature Date

Re-disclosure of this information is prohibited without the written consent of the person to whom it pertains. This authorization is intended to be in compliance with applicable Federal and/or State Laws.