Authorization for Release of Medical Information

Patient Information

Patient Name: _____ DOB: _____ Phone: _____

Address: _____

I hereby authorize Family Health Primary Care to (please check one):

☐ Release Information To ☐ Obtain Information From

Recipient/Provider: _____

Address/Phone/Fax: _____

Information to be Released (check all that apply):

☐ Complete Record ☐ Office Notes
☐ Lab Results ☐ Imaging
☐ Immunizations ☐ Meds
☐ Other

Purpose of Disclosure (check all that apply):

☐ Care/Treatment ☐ Insurance
☐ Legal ☐ Personal Use
☐ Other

Authorization Expiration

☐ 1 year ☐ On date: _____ ☐ Upon completion

Patient Rights

- I may revoke this authorization at any time by written request.
- Revocation won't affect information already released.
- Information may be re-disclosed and not protected by HIPAA.
- Treatment or benefits are not conditioned on signing this form.

Signature

Patient/Legal Rep: _____ Date: _____

Relationship to Patient: _____

Office Use Only

Completed By: _____ Date: _____