RELEASE OF MEDICAL INFORMATION

Patient's Last Name ____________________________________ First ________________________ Middle Initial _______

Social Security # ____________________________________ Date of Birth ____________________________________

I AUTHORIZE FAMILY MEDICINE HEALTHCARE TO:

❏ **OBTAIN INFORMATION FROM** ❏ **RELEASE INFORMATION TO** (INCLUDING DRUG AND/OR ALCOHOL RECORDS; HIV TESTING RESULTS, ETC.)

Name of Physician/Facility ____

Address ____

City, State, Zip ____

Phone ____ Fax ____

PURPOSE OF THE USE OR DISCLOSURE:

❏ At the request of the individual (patient initiated authorization)

❏ Other (please specify) ____

REASON FOR REQUEST:

❏ Transferring to a new physician ❏ Records requested by specialist

❏ Moving out of the area (new address) ____

❏ Other (please specify) ____

INFORMATION TO BE PROVIDED:

❏ Entire medical record	❏ Laboratory reports	❏ Medications
❏ History & Physical	❏ Pathology reports	❏ Consultations
❏ Progress Notes	❏ X-ray reports	❏ Immunization record

❏ Other (please specify) ____

I understand that I have the right to refuse to sign this **AUTHORIZATION**.

I understand that this **AUTHORIZATION** is valid for 12 months from the date of signature below, unless otherwise noted. **EXPIRES** ____________

I understand that there will be a fee for copying medical records. **INITIALS** ________________

I understand that I may revoke this **AUTHORIZATION** at any time by notifying **FAMILY MEDICINE HEALTHCARE** in writing. The revocation will only be effective from the date it is received by **FAMILY MEDICINE HEALTHCARE** and will not apply retroactively.

____ ______________________________

Signature of patient or parent/guardian if minor | Date

____ ______________________________

Printed name of patient or parent/guardian if minor | Relationship to Patient

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