Physicians of Family Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____

(Print patients full name) Birth date (Mo/Day/Yr)

_____ _____

(Street Address) Social Security Number

_____ _____

(City,State,Zip Code) Phone (Home) / (Cell)

At the request of the individual, I _____, do hereby authorize _____ to release:
(Patient's Name) (Name of Doctor/Facility)
Phone/Fax _____

DATES OF _____

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	_____ OTHER_____
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	_____
_____ OPERATIVE NOTES	_____ EKG/EEG/CARDIAC CATH	_____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City,State,Zip - Phone/Fax number

PURPOSE OF DISCLOSURE:

_____ REFERRAL TO SPECIALIST _____ INSURANCE _____WORKER'S COMP ____CHANGE OF DOCTOR
_____ LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____ PERSONAL _____CONTIUING CARE

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate

Date

NOTE: <u>There will be a charge for a personal copy or the permanent transfer of your records. Bactes has been contracted to provide this service and will invoice you directly.</u>