

RELEASE OF MEDICAL INFORMATION

This authorization grants permission to the party named below to receive any and all communications (telephone communication, answering machine messages, as well as any other common means of communication including digital communications), medical records (including but not limited to: appointment information and scheduling, evaluation and treatment records (including mental health, genetic, substance abuse and HIV diagnoses), radiology, pathology, laboratory or any other test findings), medication information (including picking up non-narcotic medications/prescriptions), diagnosis and treatment plans and financial information.

I hereby authorize the practice, my provider, their staff and/or designee to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named.

NAMED PARTY: _____

RELATIONSHIP TO PATIENT: _____

I understand that this authorization will expire 1 year from the date signed unless otherwise revoked. I understand that I may revoke this authorization at any time by notifying the practice in writing. However, if I do revoke the authorization, it will not have effect on any actions taken by the practice, provider, staff or their designee prior to the receipt of the revocation.

Patient Printed Name

Date of Birth

Patient Signature

Date