FAMILY PRACTICE CENTER PC

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ **Date of Birth:** _____**Phone:** _____

Patient Address: _____

Name/Address of Organization Providing the Information: _____

_____

Phone: _____ **Fax:** _____

Name/Address of Organization(s) or Person(s) Receiving the Information: _____

_____

Phone: _____ **Fax:** _____

Specific Description of Information Disclosed_____

_____

_____

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initials:_____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;

Initials:_____ drug and/or alcohol diagnosis, treatment, test results and reports and referral information;

Initials:_____ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or

Initials:_____ venereal disease information;

Initials:_____ genetic testing, test results, counseling, reports, treatment, and referral information.

Purpose of Disclosure:_____

_____

You must read and initial the following statements:

1. I understand this Authorization will expire on _____/_____/_____ (DD/MM/YR) or on the following event: Termination of the Physician/Patient Relationship. **Initials:** _____
2. I understand that I may revoke this Authorization at any time by notifying this Practice's Privacy Officer in writing, but if I do, it will not have any effect on any actions this Practice took before they received the revocation. **Initials**: _____

_____ _____ _____

Signature of Patient or Representative | Relationship to Patient | Date

_____ _____

Witness | Date

You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.

☐ **N/A. If this Authorization is for marketing purposes, remuneration is/is not involved (Provider circle one).**

12/2009