COMPASSIONATE FAMILY MEDICINE
AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION TO ANOTHER FACILITY/PHYSICIAN

Patient's Name: _____________________________________ DOB: _______________________

Address: ____ Date: _______________________

I hereby authorize to release my medical records from **Compassionate Family Medicine** to:

Facility/Physician: ____

Address: ____

Phone #: ______________________________ Fax #: __________________________________

Purpose For Disclosure: (Circle)

Continued Care   Attorney/Legal   Disability Determination   Personal Uses

Insurance Claim/Application   Transfer Care   Other (Specify): ______________________

Include Information (if applicable) pertaining to: (Circle all that apply)

Mental Health   Drug/Alcohol   HIV/AIDS   Communicable Treatment

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. **I understand Compassionate Family Medicine may charge a processing fee for this service.**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time exempt to the extent that the action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

____   _______________________

Print Patient Name   Date

____   _____________________________________

Signature of Patient   Legal Representative of Patient