AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Favia Primary Care

Patient Name_____Date of Birth_____
Other Names/Aliases Used _____
Address _____
Phone Number _____

I hereby authorize that the protected health information regarding the above named person be forwarded:
From: _____
Address _____
City _____ State _____Zip _____

To: _____
Address _____
City _____ State _____Zip _____

Purpose or need for information: _____

Disclosure will include: (check all that apply):

■Registration Information	■Progress Note	■History & Physical
■Laboratory Reports	■Radiology Reports	■EKG Reports
■Consultation Reports	■ Other _____	

Records from the period (dates) from _____ to _____

I must check one or more of the following types of health information that I do NOT want released to the above Recipient. I understand that I if I do not check any of the three (3) boxes, the health information released to the named Recipient may include any of the following:

_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse
_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment
_____ Psychiatric, psychological records or evaluation and/or treatment for mental, Physical and/or emotional fitness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and or evaluation

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that the action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in 1 Year** after signing. I have the right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____

Signature of Patient/Parent or Legal Guardian Date

_____

Printed name of Patient/Parent or Legal Guardian