SOUTH TABOR
FAMILY PHYSICIANS LLP

Authorization to Release Medical Information

Patient Name _____ Former Name (if any) _____
Current Address _____ D.O.B _____
Home Phone _____ Cell Phone _____ Work Phone _____

I Authorize Information Release FROM: (Please Print)	Please Send My Records TO:
Name _____	Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

Purpose of Release

☐ Transfer of care ☐ Insurance change ☐ Legal
☐ Moving ☐ Personal use ☐ Other _____

Type of Information To Be Released

☐ General Medical Records (Consists of the last two years of treatment)

☐ **Specific Information Only**: please specify _____

Protected or Sensitive Information: I understand that certain information cannot be released without specific authorization as required by State/Federal Law. **BY INITIALING** I authorize the release of the following protected or sensitive information:

_____ Drug/Alcohol Diagnosis/Treatment/Referral Information
Initial

_____ Mental Health/Treatment
Initial

_____ Genetic Testing Information
Initial

_____ HIV/AIDS Information
Initial

You will not be denied treatment if you refuse to sign the authorization form unless treatment to be provided is considered research related treatment.

You have the right to revoke this authorization at any time, provided that you do so in writing to South Tabor Family Physicians. If you revoke this authorization, we will no longer use or disclose information about you for the reason covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

This authorization will expire in 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose, unless otherwise specified: _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law.

BY: _____ Date: _____
Signature of Patient or Patient's Representative

Description of Representative's Authority: _____

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