WHITE ROCK
FAMILY HEALTH

AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize _____to disclose my individually health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory results, medical history treatment, or any other such related information. 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 health care will not be affected if do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non health care provider. The released information may no longer be protected by federal and state privacy regulations.

Print Patient Name _____Date of Birth_____ S.S # _____

Patient Address _____Phone _____

Date(s) of Service (if known) _____

Description of information to be releases: (Check all that apply)

_____ Emergency Room
_____ History and Physical
_____ Nurse Note's
_____ Progress Notes
_____ Discharge Summary
_____ Radiology Reports
_____ Consultation Reports
_____ Physician's Orders
_____ Operative Records
_____ Radiology Films
_____ Admission/ Registration Records
_____ Laboratory Reports
_____ Billing Records
_____ Other: _____
_____

Description of the purpose of the use and or disclosure: _____
_____

The health information described herein shall be released to: (Check the appropriate category)
____Hospital ____Physician _____Insurance Company _____ Attorney _____Patient ____ Other

Name _____ (Check the appropriate delivery method)

Address_____ ____Mail ____ Fax ____ Pick up Records ____ Other

City, State, Zip _____ Phone _____ Fax Number _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization o be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later then the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patients Representative Date

_____ _____
Printed Name of Patients Representative Date

_____ _____
Relationship to Patient or Legal Authority (attach supporting Documentation)