ROCHESTER
FAMILY MEDICINE PC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ (first name and last name), _____(date of birth),

hereby give my permission to **Rochester Family Medicine PC (RFMPC)** to release the following information (check all that apply):

- ☐ My complete medical records (incl. all lab reports and radiology reports)
- ☐ Lab test results
- ☐ HIV, AIDS and other communicable disease test results
- ☐ Radiology reports/exams
- ☐ Original x-ray films (films remains at RFMPC and must be returned within 30 days)
- ☐ My name and comments, including quotes, made by me regarding my care and treatment at RFMPC
- ☐ Other: _____

Please indicate where we should send copies of the information above: _____
_____
(include name, organization, telephone number, fax number and mailing address).

NOTE: Should you authorize us to release your name and comments regarding your care you are authorizing us to provide that information to any media sources.

The above information is being released for the purpose of: _____
(unrestricted and unlimited purpose if left blank)

Expiration Date of Authorization: This authorization is effective through _____/ _____ /_____
unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Rochester Family Medicine PC. You should contact the Privacy Official to terminate this authorization.

Potential for Re-disclosure: I understand my information may be mailed, faxed or picked-up in person. The person or organization sent or transporting the disclosed information under this authorization may disclose information again. It may not be possible to ensure your right to the protection of the privacy of this information once RFMPC releases/discloses it to another party.

Rights of the Individual: You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

Effect of Refusing Authorization: If you refuse to sign this authorization, Rochester Family Medicine PC will not deny you any treatment except treatment that you have requested for the purpose of disclosure to others.

SIGNATURE

Signature: _____Patient Name:_____ Date : _____

_____ _____
Name of Patient Representative Signing for Patient
(required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient