



RELEASE OF MEDICAL INFORMATION

Patient Name

Address

Phone

Date of Birth

Social Security Number

In accordance with HIPAA regulations, we require written authorization prior to sending any protected health information. If you wish for your medical records to be sent to any family members please list below their names and addresses.

Upon signing this form, you are granting consent for our practice to use and disclose your protected health information for the purposes of payment, treatment and health care operations.

If you request more detailed information about how we may use and disclose this protected health information please consult with our staff. You have a legal right to review our full policy regarding the release of protected health information before you sign this consent, and we encourage you to ask any questions you may have. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of payment, treatment or health care operations, however, we are not required by law to grant your request. If we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Please Initial if you authorize us to speak to any of the following regarding your health information:

Spouse Mother Father Daughter Son

Please write the names and relationship of any other friends/family/ health care providers you authorize us to speak with: _____

Signature

Date