



## FORM 3.4 : AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_ ACCT. # \_\_\_\_\_

RELEASE RECORDS FROM:

RELEASE RECORDS TO:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:**

<input type="checkbox"/> History and physical examination	<input type="checkbox"/> Consultation report
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Financial record
<input type="checkbox"/> Lab reports	<input type="checkbox"/> Complete record
<input type="checkbox"/> X-ray reports	

***I specifically authorize the release of information relating to:***

<input type="checkbox"/> Substance abuse (including alcohol/drug abuse)
<input type="checkbox"/> Mental health
<input type="checkbox"/> HIV/AIDS related information (including test results)

**DATES OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED:** \_\_\_\_\_  
 (State time period or "all")

- I will pick-up my medical records from Family Practice Associates P.C.
- I wish to have my medical records  mailed or  faxed to the above.

***I understand and acknowledge that:***

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Family Practice Associates P.C.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.
3. This authorization is effective for \_\_\_\_\_ months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to \_\_\_\_\_. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

\_\_\_\_\_  
Signature of patient or patient's personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed by personal representative