Family Practice
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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:

☐ History and physical examination	☐ Consultation report
☐ Progress notes	☐ Financial record
☐ Lab reports	☐ Complete record
☐ X-ray reports	

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)
☐ Mental health
☐ HIV/AIDS related information (including test results)

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

PURPOSE OF RELEASE:

☐ Transferring Medical Care to Another Provider (please inactivate me in your system)	☐ Insurance Coverage
☐ Seeing a Specialist or Other Provider (do NOT inactivate me in your system)	☐ Other

☐ 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

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Relationship to patient if signed by personal representative