Partners in Family Care

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Authorization for Disclosure of Health Information

I authorize the release of the following information from the health records of:

Patient Name: _____ Date of Birth: ____/ ___/ _____
(Please Print)
Address: _____ City: _____ St: _____ Zip_____

Social Security Number:_____/ _____/ _____ Telephone #:(____) _____-_____

Information to be disclosed:

(____) Complete Health Record (____) other records requested: _____Lab Reports
_____Radiology Reports
(____) OB Records _____Consultation Reports
_____History & Physical Examinations
****** **If more than 30 pages PLEASE MAIL ******** _____Discharge Summary
_____Other not mentioned_____

For the purpose of: (____) Transfer Care (____)Continue Care
For the dates of: (____)1st point of care, (____)Last 5 yrs, (____)Last 3 yrs
(____) Specific date: _____ and /or/ to _____

I request that the above information be sent: (Choose #1 or #2)

#1. From: Dr._____ **To:** Partners in Family Care
Address: _____ Fax: 620 345 6419
City: _____ See mailing address above
Phone #:_____ Fax #: _____

#2. From: Partners in Family Care **To:** Dr._____
Fax 620 345 6419 Address_____
See mailing address listed above City_____

Federal Law requires that you read and understand the following statement:
My medical health information MAY contain any of the following:
Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)
Behavioral or Psychiatric care
Alcohol and /or Drug Abuse treatments
I agree that any information contained in my medical record that pertains to any federally protected information is approved by me or my legal representative to release to the above named person/facility: **X**_____
This information is to be disclosed for the purposes of continuing medical care only. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand this authorization may be revoked in writing at any time, except that action has already been taken in reliance of this authorization.

Signed: **X**_____ Date: _____

Relationship to patient if not self: _____

6/20/17