Family Practice Associates
a professional corporation

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# FAMILY PRACTICE ASSOCIATES, INC.

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## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ _____ ____
Last First MI

Address _____ Phone Number (___) _____

DOB ___ - ___ - ___ Social Security # _____ - ____ - _____

I hereby authorize: _____
Healthcare Provider or Facility
_____
Street Address
_____ _____ _____
City State Zip Code
_____ _____
Phone Number Fax Number.

To provide information to: _____
Person, Healthcare Provider or Facility
_____
Street Address
_____ _____ _____
City State Zip Code
_____ _____
Phone Number Fax Number

The following information: ☐ Complete Medical History ☐ Radiology and/or Lab Reports
☐ Partial Medical History From _____ to _____
☐ Emergency Room Reports ☐ Other (Specify) _____

The sole purpose of this disclosure is (circle):

☐ Treatment/Continuity of Care ☐ Personal ☐ Insurance-Health, Life
☐ Personal Injury Claim ☐ Auto Accident Claim

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, HIV test results, and AIDS, Sexually Transmitted Diseases, alcohol and/or drug dependence abuse. This authorization expires ONE YEAR from the date of signature. This authorization may be revoked by written notice at any time prior to this date. I understand that any information released prior to the revocation cannot be retrieved and FAMILY PRACTICE ASSOCIATES, INC. will not be held responsible for such disclosure.

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Representative Signature Date

_____ _____
Witness Signature Date

*Re-disclosure of this information is prohibited without the written consent of the person to whom it pertains. This authorization is intended to be in compliance with applicable Federal and/or State Laws.*