Athens Family Medicine

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Current Address: _____

Daytime Phone #: _____

I AUTHORIZE INFORMATION RELEASE *FROM*:	I AUTHORIZE INFORMATION RELEASE *TO*:
Facility Name:	Facility Name:
Address:	Address:
Phone #:	Phone #:
Fax #:	Fax #:

Type of Information to be Released

- ☐ All Records
- ☐ Records from _____ to _____
- ☐ Most recent office visit
- ☐ Most recent lab
- ☐ Radiology Report(s): _____
- ☐ Immunizations records
- ☐ Medication records

Protected/ Sensitive Information

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space below.

✓ *I understand that the information used or disclosed pertinent to this authorization may be subject to redisclosure and no longer be protected under federal law. I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral.*

_____ HIV/ AIDS Information
Initial

_____ Genetic Testing Information
Initial

_____ Mental Health Information
Initial

_____ Drug/ Alcohol diagnosis, treatment, or referral information
Initial

I understand that I may refuse to sign this authorization and my refusal will not affect my ability to obtain healthcare services or reimbursement for services. Refusal to sign only means I will not receive health care services if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to provide that disclosure. My refusal to sign will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I may inspect or obtain a copy of health information that I am being asked to disclose. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire 24 months from the date of signing.

_____ _____
Signature of patient or patient's legal representative Date

_____ _____
Print patient name or name of patient's legal representative (If applicable) relation to patient ID Verified?