Valdosta Health & Wellness Clinic

A NEW BEGINNING, NATURALLY

Authorization to Release Healthcare Information

_____ _____

Name Date of Birth

I request and authorize Valdosta Health & Wellness Clinic to release healthcare information of the patient listed above to: (ex: family or providers)

NAME	RELATION	ADDRESS	PHONE

This request and authorization applies to:

___ All Medical Records ___ History & Physical ___ Progress Notes

___ Lab Reports ___ Medication Record ___ Imaging Reports

___ Other

I understand that information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Federal law prohibits the disclosure of the above information without written consent of the patient or authorized representative. I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the medical records director or designee. I understand that that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary, and I need not sign this form in order to assure treatment.

_____ _____

Signature Date