



**Authorization for Release of Information**

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Release Information FROM (who has the information you want to be released):**

Provider/Facility Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Release/Send Information TO (where you want the information sent):**

Provider/Facility Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Information to be Released (what information you want sent or released):**

- Complete health record
- OR** only specific portions of my health record to include the following selected categories:
  - Assessment
  - History/Physical
  - Laboratory Reports
  - Progress Notes
  - Discharge Summary
  - Treatment Plans
  - Medications
  - Immunizations
  - Mental Health
  - Emergency Reports
  - Demographic Information
  - Social History/Information
  - Surgical Reports
  - Pathology Reports
  - Radiology Reports
  - Radiology Images
  - Billing Records
  - Other: \_\_\_\_\_

Records released may include sensitive information such as mental health/chemical dependency treatment, HIV/STD or pregnancy testing results. If there is specific information you do not want released, please specify:

Specific dates/years of records to be released. If no defined dates are listed, patient consents to release of all dates of records identified above: \_\_\_\_\_

**The following information requires special consent.** Even if you indicate “complete health record” above, you must specifically request the following information to be released:

- Chemical dependency program
- Psychotherapy notes (cannot be combined with any other consent)

**Purpose of Release (why the information is needed):**

- Continuing care
- Transfer of care
- Patient request
- Disability Forms
- Insurance
- Legal
- Workers’ compensation
- Other: \_\_\_\_\_

**Release Instructions (how and when you want the information to be released):**

- Mail
- Patient Portal
- Pick Up
- Fax
- CD/DVD
- Email: \_\_\_\_\_
- Care Quality (Electronic Health Record Communication)
- Other: \_\_\_\_\_

Date information is needed (please allow adequate time for processing): \_\_\_\_\_

**Acknowledgment:**

- By signing this form, I authorize the releasing entity identified above to disclose my above health information to the receiving party identified above.
- This authorization will expire one (1) year from the date signed below unless another date is specified:  
\_\_\_\_\_
- I may revoke this authorization in writing at any time by sending notification to the releasing entity, except to the extent that any person or entity has already relied on my authorization.
- Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.
- FocusPoint Primary and Urgent Care PLLC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I may be charged for copies in accordance with state and federal law.
- A photocopy or facsimile of this authorization will be treated the same as the original.
- I will receive a signed copy of this authorization.

\_\_\_\_\_  
Signature of Patient (or person authorized to sign for patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Person Signing (if not patient)

\_\_\_\_\_  
Relationship to Patient