Medical Release of Information

SFH
FAMILY PRACTICE SPECIALIZING IN GERIATRICS

Patient Information

Name _____ Gender ◯ Male ◯ Female

Date Of Birth _____ Phone Number _____

Address _____

City_____State _____ Zip Code _____

I hereby authorize the release of my medical information as described below:

1. Purpose of Disclosure

___ Personal Use
___ Transfer to New Provider
___ Insurance Purposes
___ Other: _____

2. Information to be Released

- Entire Medical Record
- Specific Information (check all that apply):
  ___ Medical History
  ___ Laboratory Results
  ___ Imaging Reports
  ___ Diagnosis and Treatment Plans
  ___ Progress Notes
  ___ Prescription Information
  ___ Other: _____

3. Provider or Facility Releasing Information

Name of Healthcare Provider/Facility:
_____
Address: _____
Phone Number: _____
Fax Number (if applicable): _____

4. Recipient of Information

Name of Individual or Organization Receiving Information:
_____
Address: _____
Phone Number: _____
Fax Number (if applicable): _____

5. Right to Revoke Authorization

I understand that I may revoke this authorization at any time by submitting a written notice to the healthcare provider. I acknowledge that any revocation will not apply to information already disclosed prior to the revocation.

6. Acknowledgement and Signature

I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I have the right to refuse to sign this authorization, and my treatment, payment, or eligibility for benefits will not be affected by my refusal.
By signing below, I acknowledge that I have read and understood the contents of this authorization form.

Patient's Signature: _____

Date: _____

If signed by someone other than the patient (e.g., legal guardian or authorized representative):
Name of Representative: _____
Relationship to Patient: _____
Signature: _____
Date: _____