Name: ____ DOB: ___________________ Medical #: ___________________

I give permission to release the health information of:

Patient Name: ____ Date of Birth: _______________________

Street Address: ____ Last 4 numbers of SSN:__________

City, State, Zip: ____ Telephone: ( ) ______________________________

Email address: ____

Release Information From:

____

____

____ (Phone number)

____ (Fax number)

Release Information To:

____

____

____

(Street Address or PO Box, City, State, Zip Code)

____ (Phone number)

____ (Fax number)

PURPOSE OF RELEASE (check reason):

___ Request of individual/personal ____ Continued patient care ______Transfer of Care

___ Insurance _____ Legal purpose including discussions & proceedings Other______________________________

Fill in dates of treatment for records to be released:

Treatment dates: From _______________________________To _________________________________

Entire record unless otherwise noted below:

____

DELIVERY METHOD: ____ Reg.US Mail ____ Pick-up ____ Fax, where permitted _____ Overnight/Express Mail Service, where permitted ____ Secure email ____ Other: ______________________________

PATIENT'S RIGHTS – I understand that: I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice. This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases. Community Medical will not share or use my health information without my permission other than by ways listed in our Notice of Privacy Practices or as required by law. A fee may be charged for providing the protected health information. I have a right to receive a copy of this form upon request. This permission expires one year after the date of my signature unless another date or event is written here: ______________________________

Signature: ____

Print Name: ____ Date:______________