Authorization to Release Medical Information to Sound Health Physicians:

Name: ____ Birthdate: ___/___/______

Information to be released from (name, address, fax):

Specific Information:

☐ Complete Medical Record

☐ Last 2 years of medical records

Other: ____

AUTHORIZATION:
I understand that my records may contain information regarding the diagnosis of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. By my signature below, I authorize this information to be released in its entirety unless otherwise indicated below.

Exclusions: _____HIV/AIDs ______Substance Abuse ______Psychiatric Records

I understand I do not have to sign the authorization to obtain health care benefits (treatment, payment, or enrollment). I understand I may amend or revoke this authorization in writing any time. I have been furnished with a copy of the Notice of Privacy Practices for this office and may request a copy at any time. I understand this information may be utilized, maintained, and/or re-disclosed by the recipient per organizational policy and is subject to Privacy Laws.

This authorization will expire one year from the date signed unless otherwise specified.

Signature ____**Date:** _____/_____/ _______

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F: 888 843 7076
E: info@sound-health.us