MOUNTAIN DOCS
Family Medicine, PA

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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1. I, _____, hereby authorize _____
   (name, address, phone or fax)
   to release health information.

2. The following information to be disclosed.

   a. Only most recent records Specific dates to be released _____ to _____
   b. All medical records
   c. Lab work only
   d. Hospital records
   e. CT Scans / X-rays / MRI / etc.
   f. Other _____

   For the purpose of _____

   _____

3. I understand that signing this form will authorize the release of sensitive information (including psychiatric care, HIV/AIDS, or treatment of alcohol / substance abuse). I also fully understand that only information relevant to the requester's need (diagnostic / treatment for physicians, processing of claim / pay of patient bill, etc.) will be released unless disclosure otherwise is permitted by law.

4. I do not object to this information being transmitted through mail, fax or modem.

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reference to this authorization. Unless otherwise revoked. THIS AUTHORIZATION WILL EXPIRE 6 MONTHS FROM THE DATE OF THE SIGNATURE.

   Patient Name: _____ Date of Birth: _____

   SSN (Social Security Number): _____

   Signature of Patient: _____ Date: _____

   I confirm that I am legally authorized to speak in the patient's behalf regarding disclosure of medical information regarding this patient.

   _____ Date: _____
   Parent / Legal Guardian / Authorized Representative

   _____ Date: _____
   Relationship to Patient

   _____ Date: _____
   Witness to Signature