France Avenue Family Physicians, P.A.

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Birthdate _____/_____/_____
(please print clearly)
Previous Names:_____ Phone #_____ Other # _____

Address: _____
(Street) (City, State) Zip

This will authorize _____ to release information to France Avenue Family Physicians, P.A.

This will authorize France Avenue Family Physicians, P.A. to release records to:

_____
Name/organization

_____
Street Address City State Zip Code

_____
Phone Number Fax Number

The following information is to be released (please check all appropriate boxes):

Office Notes	Laboratory Results	EKG
Complete Preventative Exams	Radiology Reports	Immunization Record
ER Notes	Hospital Admission/Discharge Notes	Consultation Notes
HIV/AIDS Records	**STD testing results**	**Psychological Notes**
All Records	Other _____ (please specify)	

For the following date(s) of treatment/ condition: _____

I am requesting the information be released for the following purpose:

Transferring care to another clinic Personal use Sharing information with another clinic
To provide an individual access to my medical information: _____
(please provide their name and relationship with you here)
Other: _____

All records pertatining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here: _____
Please indicate any restrictions here: _____
I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____
The expiration period noted here may exceed one year only in certain situations as specified by law.
I understand there may be a retrieval and copy charge associated with this released and these charges are determined yearly by law.
I understand that once information is released pursuiant to this authorization, France Ave. Family Physicians, P.A., can not prevent the re-disclosure of the information to a third party.
I understand this authorization must be filled out completely and signed in order to be valid. A copy that has not been altered will be considered as valid as the original.
Except for research-related treatment, France Ave. Family Physicians, P.A, will not condition treatment on my signing this authorization.

Signature: _____ Date: _____

Authorized Person's Signature: _____ Relationship :_____