

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):

- | | | |
|--|---|--|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Complete Preventative Exams | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> ER Notes | <input type="checkbox"/> Hospital Admission/Discharge Notes | <input type="checkbox"/> Consultation Notes |
| <input type="checkbox"/> HIV/AIDS Records | <input type="checkbox"/> STD testing results | <input type="checkbox"/> Psychological Notes |
| <input type="checkbox"/> All Records | <input type="checkbox"/> 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 pertaining 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 pursuant 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:** _____