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AUTHORIZATION TO RELEASE MEDICAL AUTHORIZATION

PATIENT'S FULL NAME:_____ MAIDEN NAME:_____
Last First Initial

DATE OF BIRTH:_____ LAST 4 DIGITS OF SS#_____ GENDER: M/F TELEPHONE# ( )_____

ADDRESS: STREET:_____

CITY:_____ STATE:_____ ZIP:_____

I,_____HEREBY AUTHORIZE_____,

IT'S DIRECTOR OR AGENT, TO DISCLOSE INFORMATION CONTAINED IN THE MEDICAL RECORD OF THE PATIENT IDENTIFIED ABOVE, WHICH INCLUDES INFORMATION THAT MAY BE STORED IN A PAPER AND/OR ELECTRONIC FORMAT AS SET FORTH BELOW. HOWEVER, SUCH NOTES MAY CONTAIN INFORMATION ON GENERAL MEDICAL CARE; ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HUMAN IMMUNODEFICIENCY VIRUS (HIV) OR ACQUIRED IMMUMODEFICIENCY SYNDROME (AIDS) OR AIDS RELATED COMPLEX (ARC); COMMUNIABLE DISEASES OR INFECTIONS; INCLUDING SEXUALLY TRANSMITTED DISEASES, VENEREAL DISEASES, TUBERCULOSIS AND HEPATITIS; DEMOGRAPHIC INFORMATION AND TREATMENT RECEIVED AT OTHER HEALTH CARE PROVIDERS.

NAME OR TITLE OF PERSON/ORGANIZATION AND ADDRESS TO WHOM INFORMATION IS TO BE:

☐ **DISCLOSURE TO:_____** ☐ **RELEASE FROM:_____**

_____ _____

_____ _____

_____ _____

THE PURPOSE OR NEED FOR SUCH DISCLOSURE:

____AT THE REQUEST OF THE PATIENT _____PERSONAL USE _____CONTINUATION OF CARE ____ATTORNEY

____WORKMAN'S COMPENSATION _____INSURANCE _____DISABILITY ____OTHER_____

SPECIFIC INFORMATION TO BE DISCLOSED/OBTAINED AS RELATED TO ABOVE

____ER MEMO ____OUTPATIENT VISIT ____X-RAY/LAB ____DISCHARGE SUMMARY ____IMMUNIZATIONS

____DIAGNOSIS/DATES ____OTHER (SPECIFY) _____

THIS AUTHORIZATION IS VALID ONLY IF RECEIVED BY DR. ANGELA BULLY'S OFFICE WITHIN 60 DAYS OF THE DATE SIGNED. THIS AUTHORIZATION EXPIRES WHEN THE PATIENT INFORMATION IS DISCLOSED AS PERMITTED IN THE AUTHORIZATION, OR ON_____ (DATE CANNOT EXCEED ONE YEAR FROM DATE SIGNATURE BELOW).

<u>I MAY REVOKE THIS AUTHORIZATION AT ANYTIME</u>. REVOCATIONS TO THIS MUST BE PRESENTED IN WRITING. REVOCATION WILL NOT APPLY TO THE INFORMATION THAT HAS ALREADY BEEN RELEASED PURSUANT TO THIS AUTHORIZATION.

SIGNATURE: _____ RELATIONSHIP (IF OTHER THAN PATIENT) _____
PATIENT, PATIENT OF MINOR, LEGAL GUARDIAN REPRESENTATIVE, PERSON UNDER A POA*

DATE: _____

***IF LEGAL GUARDIAN, PERSONAL REPRESENTATIVE OR PERSON WITH AUTHORITY UNDER A DURABLE MEDICAL POWER OF ATTORNEY, A COPY OF APPROPIATE DOCUMENTATION IS NECESSARY FOR RELEASE.**