

AUTHORIZATION FOR RELEASE OF INFORMATION FROM :

I here by authorize **TROPHY CLUB FAMILY MEDICINE** to disclose my individually identifiable health information as described below which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV)and Acquired immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency laboratory test results, medical history, treatment or any other information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign.

I understand that if the recipient authorized to receive the information is not a covered entity, (insurance company or non-health car provider); the released information may no longer be protected by federal and state privacy regulations.

Patient Name (please print)

Date of Birth

Patient Address (city state and zip)

Social Security Number

Specific Date(s) of Service

All Dates of Service

Phone Number

Information to be release: (please check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> Radiology Reports and Films | <input type="checkbox"/> Registration Records | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Visits & encounters | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> laboratory Reports | <input type="checkbox"/> Operative Records | <input type="checkbox"/> Others | |

Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to** : (please circle the one that applies)

Category: Hospital Physician Insurance Company Attorney Patient Other

Name of Person or Entity (please print)

Phone Number

Address (City, State and Zip)

Fax Number

Delivery Method:

Mailing Address

Fax

Pick-Up Records

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____(Expiration date/event.)

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later then the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN

DATE