

**Partners In Internal Medicine**

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**Medical Release of Protected Health Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

I hereby authorize the professional office of \_\_\_\_\_ to release **ALL** health information identifying me (including if applicable, information about HIV/AIDS, substance abuse treatment including mental health services information) under the following terms:

Detailed description of any information **NOT** to be released: \_\_\_\_\_

**Please include the COMPLETE address of where you would like your records sent to. Requests can not be processed without this information.**

Send records **TO**: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

List Purpose: \_\_\_\_\_

i.e. per request of individual/patient, Workman's Comp, Life Insurance Company, Transfer of Physician, Continuity of Care, Judicial Purposes

Expiration date for this release: \_\_\_\_\_

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When your health information is disclosed as provided in this release, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I have read and understand this form and I am signing it voluntarily. I authorize the disclosure of my health information as described in this form. I understand that I may revoke this request at anytime by notifying the office in writing and that it will be effective on the date received.

**I also understand that there are fees associated with the release of my health information to persons other than health professionals. (i.e Insurance companies, for patient's personal use, disability)**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship and the source of authority to sign this form:

Print Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Source of Authority: \_\_\_\_\_