Partners In Internal Medicine

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MEDICAL RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient Number and/or Date of Birth: _____

Patient address: _____

Patient Phone Number: _____

I hereby authorize the professional office of _____ to release **all** health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment including mental health service information) under the following terms.

Detailed description of the information **NOT** to be released: _____

To whom may the information be released: Name**:** **Partners In Internal Medicine**_____

The purpose(s) for the release (example per request of individual/patient, Workman's Comp, Life Insurance Company, Continuity of Care, Transfer of physician(s), Judicial purposes:

List Purpose:_____

Expiration date or event relating to the individual or purpose for the release: _____

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. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM AND UNDERSTAND THAT THERE MAY BE FEES ASSOCIATED WITH RELEASE OF MY HEALTH INFORMATION.

Patient Signature: _____ Dated: _____

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

Relationship to Patient: _____Print Name: _____

Source of Authority: _____