

Gibbons Family Medicine

Medical Release of Information Form

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

Home Phone: _____ Other Phone: _____

Address, City, State, Zip: _____ Fax: _____

I request and authorize _____
(Name of Physician and Clinic/Practice records are requested from)

To release the medical record of the above named patient to:

Name of Recipient: _____

Address: _____

City & State: _____ Zip Code: _____

Phone Number: _____

Reason for release: _____

This release and authorization applies to: (initial appropriate line)

Health Care information relating to the following treatment condition or dates of treatment:

_____ This information may contain x-ray reports, laboratory reports, EKG reports, or other diagnostic reports, consults, etc.

All Health Care information **including** information related to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

All Health Care information **excluding** information related to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

I understand I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

Signature of Patient or Legal Representative

Date

Representative Relationship to Patient

Date

Patient or Representative Phone Number

Date

Unless otherwise revoked this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.