Emanate Health Medical Group

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize _____ to disclose the following from the health record of:

Patient Name: _____ Date of Birth: _____

Address: _____ Medical Record #: _____

Phone: _____ Fax: _____

1. Purpose of Release Request

☐ Changing Providers ☐ Legal Reasons ☐ Doctor Consultation/Referral

☐ Personal Use ☐ Moving/relocating outside the area

2. Information to be disclosed: ☐ **Clinic visit(s)** ☐ **Hospital**

☐ Discharge Summary	☐ Emergency Record	☐ Most recent 2 year history
☐ History & Physical	☐ Laboratory Test(s)	☐ Progress Notes
☐ Operative Report	☐ Radiology Report(s)	☐ Complete Medical Record
☐ Consultation Reports	☐ Pathology Report(s)	☐ Immunization Records

☐ Other: _____

Please include information relating to *(initial if needed)*:

_____ HIV test results _____Substance abuse _____Mental Health _____Genetic testing

3. Please Choose One: ☐ Pick up ☐ Please mail ☐ Fax

4. I authorize the information designated above to be released **From**:	**5.** I authorize the information designated above to be released **To**:
Name of Facility: _____	Name of Facility: _____
Name of Doctor: _____	Name of Doctor: _____
Street Address: _____	Street Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax:

6. Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date), or for one year from the signature date if no date entered.

Revocation: This authorization may be revoked in writing at any time prior to the release of information. Written revocation will not affect any action taken before receipt of the revocation.

Rediscloseure: I understand that FFPMG may not lawfully further use or disclose this health information unless another authorization is obtained from me, or unless disclose is specifically required or permitted by law.

7. _____ _____ _____

Signature of patient (or legally responsible person) State relationship to patient Date