LEAVITT
FAMILY MEDICINE

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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**(All sections must be completed)**

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records from:

Doctor/Clinic_____

Address_____

Phone_____ Fax_____

I hereby authorize the release of medical records to: Leavitt Family Medicine

Purpose of disclosure: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment: _____

_____ Specific records to be released (eg. Labs, imaging reports, other):
_____

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.**

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient or Authorized Representative — Date Signed

_____

Relationship to Patient