Authorization to Release Information

Patient Name: _____ SSN# _____

Address: _____

DOB: _____ Phone: _____

I authorize _____to release copies of my medical records to:

PCC Medical Holding

Dr._____

Address: _____

City, State, Zip:_____

Phone:_____

A.) I authorize release of information for:

____ Medical Care (physicians, etc.) ____ Personal Use ____ Other: (Attorney, Insurance, Employer, etc.)

B.) I am transferring from medical office_____ to _____

C.) I authorize release of my *(refer to section D, if applicable)* _____ Entire medical record

-OR-

Medical Records for the specific treatment dates from _____to _____

D.) I authorize release of the following portions of my medical record:
(initial beside each area to be included in release)

_____ Mental Health _____ Substance Abuse _____ HIV/AIDS _____ Communicable Disease

I understand that this authorization shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

Should my case require review by a governing agency or another medical professional actively involved _in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical professional for review.

_____ _____
Patient/legal representative Date

_____ _____
Relationship to Patient Witness Date

NOTICE: The information has been disclosed to you from records whose confidentiality bas been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization is NOT sufficient for this purpose.