Authorization for Release of Medical Records to
Family Medical Associates, PC

Date: _____

Last name _____ **DOB** _____

Address _____ **MRN** _____

I authorize Family Medical Associates, PC to obtain from:

Doctor of hospital name _____ **Fax #** _____

Address _____

any information about my health and health care, including the diagnosis, treatment, or examination rendered to me during the period from:

_____ **to** _____

I expressly authorize and consent to the disclosure of my health information related to (check all that apply):

☐ Alcohol and substance use ☐ Mental health ☐ STIs including HIV/AIDS ☐ Genetic testing/counseling

CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed. After one year, a new authorization form is needed to continually disclose my PHI. I understand this authorization is voluntary and may refuse to sign it.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient or authorized representative signature: _____ **Date:** _____

Patient or authorized representative name: _____