PATIENT'S AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Information:

_____ _____ _____-_____-_____

Name Birth Date Social Security Number

Information to be released from:

_____ (____)_____

Name of Designated Physician/Clinic/Hospital Phone Number

_____

Address City State Zip

Information to be release to: ***Phone: 757-685-4325 Fax: 757-354-4932***

Holistic Family Practice **1213 Laskin Rd Suite 108 Virginia Beach Va 23451**

Type of Information to be Released:

All medical records from date of initial evaluation and treatment to the date you receive this authorization (Chart notes billing records, lab, x-rays, etc.)

The__ most recent years of pertinent information(Chart notes, billing records, labs, x-rays,etc)

Other specific information (Specific dates of treatment, date range, etc.) _____

Purpose for which disclosure is being made:

Attorney/Legal Insurance Doctor Personal Other_____

Protected Records:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/ AIDS, sexually transmitted diseases, drugs and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for all these records to be released.

I want to exclude the following information (Check all that apply)

Drug/Alcohol abuse diagnosis/treatment/testing Sexually Transmitted Disease diagnosis/ treatment/testing

HIV/AIDS diagnosis/treatment/testing Mental Health/Psychiatric diagnosis/ treatment/testing

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, Payment, or enrollment). I may revoke this Authorization in writing at any time. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may not longer be protected under Privacy laws. **The authorization will expire 90 days from the date signed.**

Signature:_____ Date:_____