ASSOCIATESIN PRIMARY CARE, LLC
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PLEASE
□ FAX □ COURIER □ US MAIL
(if more than 10 pages)

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (First, Middle, Last) Date of Birth:

Address of Patient: Telephone number of patient:

Disclosed Information:

□ Lab Reports	□ ER Record	□ Consultations	□ Mental Health Records
□ Radiology/XRay Reports	□ Operative Reports	□ Drug/Alcohol Treatment	□ EKG or Cardiac Testing
□ Medication Records	□ History and Physical	□ Discharge Summary	□ OTHER Please Specify

Information to be provided TO / FROM: (Please circle)

Name of person or institution:

Address:

Telephone Number _____ Fax Number _____

Purpose / Use of Requested Information:
□ Transfer of Care
□ Collaboration with other providers
□ Personal Use by Patient
□ OTHER (please specify) _____

Authorization:

I hereby authorize Associates In Primary Care, LLC to disclose the health information as described above. I understand that I may revoke this authorization at any time, and must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that for printed records, I may be asked to pay a reasonable fee.
My refusal to sign this authorization will not affect my ability to receive treatment.

Signature of Patient or Patient Representative: Date:

Signature of Witness Date