DEVON FAMILY PRACTICE, LLP

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize (Physician Name and or practice Name transferring from)_____

(Address)_____

to release medical information from the records of:

Patient Name_____ D.O.B._____ss#_____

Covering the period(s) of care (list applicable dates of treatment):_____

I instruct the above named entity to produce the following information (Check ONE only)

____Entire Record (subject to state regulated rates) ____Release a 2 year abstract of my records

____I would like the following specific record released_____

_____

I understand that this will include information relating to (please check if you do not want this information released)

____AIDS/HIV ____Psychiatric Care/Treatment ____Treatment for Drug or Alcohol Use/Abuse

I authorize the above listed records to be released to (Physician Name, address and phone number))_____

_____

I am requesting my records to be transferred for the following purpose (Please check one)

____ Transferring Practice ____Seeing a Specialist ____Other (please specify)_____

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective up receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Personal Representative Date

(attach proper documentation)

Your state Legislature determines the cost of records. Any payments are required prior to release.