IMMEDIATE FAMILY CARE
OCCUPATIONAL MEDICINE
C.A.R.E.S.
CHEAHA AREA REGIONAL EMERGENCY SPECIALISTS

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AUTHORIZATION FOR RELEASE OF INFORMATION

1. I hereby authorize _____

to release to: _____

_____

_____

_____ _____

Patient Name Birth Date

2. Information to be released

_____ Initial Examination _____ Discharge Summary

_____ Follow-Up Care/Progress Notes _____ Office Visit Notes

_____ Special Procedure Results _____ Other: _____

3. The above information is released for the following purpose and that purpose only. Any other use is forbidden:

_____

_____

4. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this authorization expires automatically as described above. The protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this disclosure and may no longer be protected under federal law.

5. This authorization will expire thirty (30) days from the date of my signature or as otherwise specified by date, event or condition as follows:

_____

_____

6. With respect to any mental health, alcohol/substance abuse or HIV status information that may be contained in the patient's medical records, I hereby waive my/his/her right to the privileges of confidentiality.

_____

Signature of Patient or Authorized Legal Representative Date

_____

Relationship to Patient Witness Signature

PATIENT RECEIVED COPY_____