Edgewood Family Physicians, P.C.

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name:_____ DOB:_____
Patient address:_____
City:_____ State:_____ Zip:_____

My authorization: You may use or disclose my health care information for dates ranging from _____ to _____, for the purpose of:

_____ Transferring medical care
_____ Continuing of care
_____ Personal use
_____ Legal

*I understand that my records may contain information regarding the diagnosis or treatment of HIV or other sexually transmitted diseases, drug and alcohol abuse, mental illness and psychiatric treatment.

Please **send records to** or **retrieve records from**: (circle one)

Facility/Physician:_____
Street address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

This authorization expires on _____, or one year from the date of authorization. I understand that I do not have to sign this authorization in order to get health care benefits. (treatment, payment, enrollment, or eligibility of benefits) I may revoke this authorization in writing at any time at Edgewood Family Physicians. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. Once the office discloses health information, the person or organization that receives it may be able to re-disclose it.

_____ _____
Signature of patient or legally authorized signature Date

_____ _____
Printed name of patient or authorized individual Relationship