France Avenue Family Physicians, P.A.

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Birthdate _____/_____/_____
(please print clearly)
Previous Names:_____ Phone #_____ Other # _____

Address: _____
(Street) (City, State) Zip

□ This will authorize _____ to release information to France Avenue Family Physicians, P.A.

□ This will authorize France Avenue Family Physicians, P.A. to release records to:

Name/organization			
Street Address	City	State	Zip Code
Phone Number	Fax Number		

The following information is to be released (please check all appropriate boxes):

□ Office Notes	□ Laboratory Results	□ EKG
□ Complete Preventative Exams	□ Radiology Reports	□ Immunization Record
□ ER Notes	□ Hospital Admission/Discharge Notes	□ Consultation Notes
□ **HIV/AIDS Records**	□ **STD testing results**	□ **Psychological Notes**
□ All Records	□ Other _____ (please specify)	

For the following date(s) of treatment/ condition: _____

I am requesting the information be released for the following purpose:

□ Transferring care to another clinic □ Personal use □ Sharing information with another clinic
□ To provide an individual access to my medical information: _____
(please provide their name and relationship with you here)
□ Other: _____

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here: _____
  Please indicate any restrictions here: _____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____
  The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge associated with this released and these charges are determined yearly by law.
- I understand that once information is released pursuant to this authorization, France Ave. Family Physicians, P.A., can not prevent the re-disclosure of the information to a third party.
- I understand this authorization must be filled out completely and signed in order to be valid. A copy that has not been altered will be considered as valid as the original.
- Except for research-related treatment, France Ave. Family Physicians, P.A, will not condition treatment on my signing this authorization.

Signature: _____ Date: _____

Authorized Person's Signature: _____ Relationship :_____