AUTHORIZATION TO RELEASE HEALTH INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods to:

_____ ( )_____
Who will be receiving information Phone Number

_____ ( )_____
Mailing Address or E-Mail Address Fax Number

I hereby authorize: **ATIGA FAMILY PRACTICE** to release the below indicated medical information:

(___) Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment unless marked below)
(___) Limited to the following: _____

I also consent to the specific release of the following records:
Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

(___) Drug/ Alcohol/Substance Abuse
(___) Psychiatric/Mental Health
(___) HIV/AIDS Diagnosis/Treatment
(___) Test results for Genetic Testing

DURATION: This authorization shall be effective immediately and remain in effect for one year from the date of signature below or until: _____

RESTRICTIONS:
Permissions for future use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such a disclosure is specifically required or permitted by law.

A photocopy of this facsimile for authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____ _____
Signature of Patient *or legal/personal representative* Date *Relationship if other than patient*

_____ _____
Patients Name (PRINT) DOB

(01/19/2022)