Osteopathic Center for Family Medicine
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WRITTEN AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I ____ Date of birth: ______________________
Patient name (mm/dd/yyyy)

authorize ____
Name of Physician/Healthcare Facility Address

to disclose my protected information by submitting a copy of the following records to Osteopathic Center for Family Medicine at the above address

a. Diagnosis/Problem list
b. Office and/or Consult Notes
c. Medication list
d. Lab and/or Patholgoy reports
e. Radiology reports
f. Hospital Records
g. Psychiatric/Psychological diagnoses
h. Chemical/alcohol dependence
i. AIDS/HIV testing and treatment
j. All records inclusive of any previously indicated
k. OTHER______________________

This authorization to release is for the purpose of:

___Transfer of care ___Release of Records directly to patient or legal guardian

___Coordination of care ___Other:____

Unless I revoke this authorization, it will expire 12 months or upon written revocation to be sent to Osteopathic Center for Family Medicine at the address noted above including the following: Patient Name and Address, Effective date of the Original Authorization, Statement of and effective date of revocation, Patients or Legal Guardian Signature.

I understand that refusal or revocation of permission may result in improper diagnosis or treatment, denial of health benefits or insurance or the adverse consequences. Revocation will not affect information already given out. If I have been diagnosed or treated for any of the following, I understand that Osteopathic Center for Family Medicine needs my specific consent to disclose related information. Please answer questions by circling “DO” or “DO NOT” indicating to the release to authorize or not to authorize release/disclosure of said sensitive information. I may cross out any of the following that do not apply. Such information may not be re-disclosed by the recipient without my specific written consent.

I Do/ Do Not authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse.
I Do/ Do Not authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.
I Do/ Do Not authorize the disclosure of information that refers to treatment or diagnosis of HIV infection ARC or AIDS.

I understand that I am entitled to copy of this authorization form.

Patient Signature Date

Authorized Representative/Relationship Date