Community Family Practice, PA
Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

At my request the following information may be released:

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ Marketing* ☐ On site record review by the patient
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):

☐ Other as listed

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name _____

Address_____

City, State, Zip _____Phone _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

_____Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Revised August 2013