

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS, SCHOOL & PRIMARY CARE PHYSICIANS

Patient Name: _____ Today's Date: _____

Date of Birth: _____ SSN: _____

I request and authorize the office of Jessica B. Holt, MD, PA to release healthcare information for the patient named above, to the following:
Family, Friends, School, and/or Primary Care Physician, as listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

School Name: (if applicable) _____

Primary Care Physician: _____

Therapist: (if applicable) _____

The authorization for the release and disclosure of medical information applies to: (check all that apply)

- All health care information _____
- Only dates of service from _____ to _____
- Only information pertaining to the treatment of _____
- Mental Health information, Mental retardation information _____
- Alcohol/Drug (substance) information _____
- HIVS/AIDS information _____
- Other _____

The purpose of the disclosure is: _____

I request that information **NOT** be released to the individuals listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The information to be used or disclosed pursuant to this authorization may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.

I also understand that I may revoke this authorization at any time by notifying the office except to the extent required by law. I understand that such revocation will not have any effect on any information already used or disclosed by our office before we received the intent to revoke the authorization. This authorization will expire 180 days from the date of my signature or as otherwise specified by date, event or condition as follows: _____

If neither federal nor state privacy laws apply to the recipient of this information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy laws. This authorization is voluntary and I may refuse to sign this authorization form. I understand that I am not required to sign this authorization form in exchange for the patient receiving treatment for Jessica Holt.

I authorize the office staff or provider to leave messages on my answering machine/voice mail: (Check all that apply)

Home _____ Office _____ Cell Phone _____ Pager _____

Patient/Guardian/Legal Representative Signature

Date

Relationship to patient