Freedom Family Practice

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Authorization for Release of Medical Records

Patient Information
Full Name: _____
Date of Birth: _____
Phone Number: _____
Address: _____

Records To Be Released
I hereby authorize Freedom Family Practice to release and/or disclose my medical records as indicated below:

☐ **Complete medical record**
☐ **Partial record — specify:** _____

This authorization includes the release of information that may contain the following sensitive medical data (initial next to each to consent):
____ **Substance abuse records and treatment information**
____ **Psychiatric and psychological notes**
____ **Mental health records**
____ **HIV/AIDS testing, diagnosis, and treatment information**
____ **Laboratory reports**
____ **Provider notes**
____ **Orders and referrals**

Purpose of Release
☐ **Continuity of care**
☐ **Personal use**
☐ **Insurance or legal purposes**
☐ **Other (specify):** _____

Recipient of Information
I authorize Freedom Family Practice to release my medical records to/from:

Name/Facility: _____
Address: _____
Phone: _____ **Fax:** _____

Authorization and Acknowledgment

- **I understand that I may revoke this authorization at any time by submitting a written request to Freedom Family Practice, except to the extent that action has already been taken based on this authorization.**
- **I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.**
- **I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on whether I sign this authorization.**

This authorization will expire five years from the date of signature, unless otherwise specified: _____

Signature
Patient Signature: _____ **Date:** _____

Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Patient: _____

Witness Signature (if required): _____ **Date:** _____