



RECORDS RELEASE AUTHORIZATION

Physician: _____

<p align="center">From / To (Circle One)</p> <p>Name: <u>Prima Medical Foundation</u></p> <p>Add: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p align="center">From / To (Circle One)</p> <p>Name: _____</p> <p>Add: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>
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Date(s) of Treatment: _____

I consent to release the following health information (check all that apply)

<input type="checkbox"/>	Office/Progress Notes	<input type="checkbox"/>	Consultation Reports
<input type="checkbox"/>	Hospital/ Outpatient Care	<input type="checkbox"/>	Emergency Room care
<input type="checkbox"/>	Radiology Reports	<input type="checkbox"/>	Lab Results
<input type="checkbox"/>	Other: _____		

The following information will not be released unless the specific item is checked:

<input type="checkbox"/>	Information pertaining to drug & alcohol abuse, diagnosis or treatment
<input type="checkbox"/>	Information pertaining to mental health diagnosis or treatment
<input type="checkbox"/>	HIV/AIDS test results
<input type="checkbox"/>	Information pertaining to genetic testing

This authorization shall remain in effect for one year. I understand that I have the right to receive a copy of this authorization upon request. I understand that I have the right to request restrictions on the uses and disclosures of health information; however, Prima Medical Foundation is not required to agree with the requested restrictions. I also understand that this authorization may be revoked, in writing, at any time, except to the extent that action has already been taken. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. I understand there may be a \$25 fee required to process this request and I agree to pay this amount. Having read the above information, I hereby release, hold harmless, Prima Medical Foundation, it's employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

Date

Patient Name (Print)

Patient Date of Birth

Signature of Patient/Parent/Guardian