Authorization for Release of Medical Information

PATIENT'S FULL NAME: ______________________________ DOB: ______________
ADDRESS: ____
PHONE NUMBER: ________________________

ADDITIONAL FAMILY MEMBERS (IF MINORS):
PATIENT NAME: ________________________ DOB: ________________________
PATIENT NAME: ________________________ DOB: ________________________
PATIENT NAME: ________________________ DOB: ________________________
PATIENT NAME: ________________________ DOB: ________________________
PATIENT NAME: ________________________ DOB: ________________________
PATIENT NAME: ________________________ DOB: ________________________
PATIENT NAME: ________________________ DOB: ________________________

THIS AUTHORIZES: ________________________
____
____
____

TO RELEASE INFORMATION TO: **The Family Doctor, PLLC**
1670 N Kolb Road #146
Tucson, AZ 85715
Fax: (520) 300-7090

THIS AUTHORIZATION RELEASES THE FAMILY DOCTOR AND ANY STAFF, EMPLOYEES, AND AGENTS OF ANY RESPONSIBILITY FOR INFORMATION CONTAINED IN SUCH RECORDS RELEASED IN CASE OF LOSS OR THEFT FROM MY PERSON, OR DISTRESS OF ANY TYPE CAUSED TO ME OR OTHERS. THE FAMILY DOCTOR WILL NOT BE HELD LIABLE FOR ANY MISUSE OR MISUNDERSTANDING OF THE INFORMATION CONTAINED HEREIN AS A RESULT OF THIS RELEASE.

PLEASE INITIAL NEXT TO ANY OF THE FOLLOWING CATEGORIES OF RECORDS THAT YOU WOULD **NOT** LIKE TO HAVE TRANSFERRED:
_____ Mental condition and/or treatment including psychotherapy notes
_____ Drug or alcohol and/or treatment
_____ HIV or AIDS or AIDS-related conditions or treatment

I AUTHORIZE THE RELEASE OF ALL MY MEDICAL RECORDS, INCLUDING ALL HIV AND COMMUNICABLE DISEASE-RELATED INFORMATION, MENTAL CONDITION(S), AND/OR TREATMENT INCLUDING PSYCHOTHERAPY NOTES, DRUG OR ALCOHOL TREATMENT, EXCEPT AS NOTED ABOVE.

____
Printed Name of Patient, Parent, or Guardian

____
Signature

____
Date