GENERATIONS
FAMILY PRACTICE

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RELEASE OF MEDICAL RECORD INFORMATION
Release from Generations Family Practice
This authorization expires ninety (90) days from date of signature

PATIENT NAME: _____ DOB: _____

Reason for Request: _____ Medical (continuing care) _____ Personal

_____ Medical (transferring care) _____ Other

I hereby authorize Generations Family Practice clinicians and staff to use or disclose my protected health information as described below:

1. The following person, or facility may receive disclosure of my protected health information.

Name _____

Address _____

Phone (____) _____ Fax (____) _____

2. Complete Record _____ or Partial Record _____ through _____

ATTENTION: Unless you sign here, no information may be released regarding **alcohol or substance abuse, HIV/AIDS, or mental health. YES, Disclose this information** _____
Signature

- ○ **NO, DO NOT disclose this information**

3. I understand that my protected health information may be re-disclosed by the person/facility receiving it, and would at that time no longer be protected by federal privacy regulations.

4. I understand that I may revoke this authorization at any time by notifying Generations Family practice **in writing** of my desire to revoke. However, I understand that any action already taken on reliance of this authorization cannot be reversed, and my revocation will not affect those actions.

5. This authorization expires ninety (90) days from date of signature or **sooner,** (1) if at any time I should revoke it, or (2) upon the occurrence of the following expiration event for which this disclosure was authorized.

Patients requesting a permanent transfer of records or copies for personal/legal reasons may incur a charge. Record Copy Fee is $0.75 per page for the first 25 pages, $0.50 per page for pages 26 through 100, and $0.25 for each page in excess of 100.

_____ _____
Signature of Patient/Guardian or Representative Date

Description of representative's authority to act for patient: _____