GENERATIONS
FAMILY PRACTICE

RELEASE OF MEDICAL RECORD INFORMATION

*This authorization expires **one year** from date of signature*

PATIENT NAME: _____ **DOB:** _____

I hereby authorize GENERATIONS FAMILY PRACTICE to disclose my protected health information TO:

Facility Name or Individual receiving records:_____

Address: _____

Phone: _____ Fax: _____

REASON FOR REQUEST: ____ Medical (continuing care w/ specialist) ____ Personal

____ Medical (transferring / leaving practice) ____ Other: _____

INFORMATION BEING RELEASED:

_____ **Complete Record** (this includes only records generated/ordered by Generations Family Practice. Specialist records and prior primary care records will need to be requested from the original facility)

_____ **Partial Record** (this includes only records generated/ordered by Generations Family Practice. Specialist records and prior primary care records will need to be requested from the original facility)

Information requested: _____

Dates requested: _____ thru _____

_____ ****DO NOT INCLUDE** information regarding alcohol / substance abuse (in compliance with 42 GFR Part 2), genetic testing, mental health, HIV/AIDS and other sexually transmitted diseases

PATIENT'S RIGHTS – I understand that:

1. I can cancel my permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or Generations Family Practice. Any cancellation will apply only to information not yet release by facility or practice.
2. This is a full release including information regarding alcohol/substance abuse (in compliance with 42 GFP, Part 2), genetic testing, mental health, HIV/AIDS & other sexually transmitted diseases unless indicated above.
3. Once my health information is released, the recipient may disclose or share my information with others and may no longer be protected by federal and state privacy protections.
4. GFP will not share or use my health information without my permission other than listed in the GFP Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at generationsfamilypractice.com.
5. A fee may be charged for providing my protected health information.

_____

Signature of Patient / Guardian or Representative Date

Description of representative's authority to act for patient _____