Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

Authorization to Disclose Protected Health Information

Patient Name: _____ Patient Phone: _____ Date of Birth: _____/_____/_____

The purpose of the use/disclosure is for:
☐Continuity ☐Transfer of care ☐Personal ☐Disability ☐Insurance ☐Legal ☐ Other:_____

I authorize Southwest Family Physicians to ☐Release records to:
☐Request records from:
Needed by date: _____/_____/_____

Provider/Facility Name/Individual:_____

Address: _____

Phone: _____ Fax: _____

This authorization shall begin immediately and remain in effect for not more than 180 days from this date unless another date is specified.

Please **initial** the information you want disclosed:

____ Most recent 2 year history or _____
____ Clinical chart notes
____ Prenatal / OB notes
____ Other: _____
____ Laboratory/Pathology
____ Diagnostic Imaging Reports
____ Immunizations
____ Records related to (specific dates, conditions, etc) _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

____ HIV/AIDS information
____ Genetic testing information
____ Mental health information
____ *Drug/alcohol diagnosis, treatment, or referral information

*Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care service or reimbursement for services. I understand I may revoke this authorization in writing at any time. The only exception is when information has already been released in response to this authorization.
I also understand that, in the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

_____ Date _____/_____/_____
Signature of Patient / Authorized Individual Date

If signed by other than patient, indicate relationship: _____