Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

Release of Information

I _____ give the physicians and office staff of Southwest
(Please write out name and DOB)
Family Physician's permission to discuss my medical condition with the listed person(s) below.

(Note: if a specific topic box is not INITIALED, we will be unable to discuss any treatment related to that topic.) Southwest Family Physicians may disclose health care information regarding testing, diagnosis and treatment for the following conditions:

_____Information pertaining to my medical treatment

_____Psychiatric disorders/Mental health

_____Alcohol/Substance Abuse

_____Sexually Transmitted Infections/HIV

_____All other health information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Note: This authorization does NOT allow for the sharing of copies from the patient's health record. If there is an anticipated need for copies of the patient's health record, our standard form must be completed and submitted to the medical record department.

The consent will be considered valid for 2 years or until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____