WHOLE FAMILY HEALTH CARE
CYNTHIA TAYLOR, MD, MPH, FAAFP

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name:_______________________________________ Birthdate: _____/_____/_____
SS#: ______-________-______ Previous name, if any: ________________________________

I request and authorize:

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to release to Dr. Taylor at the address above, for the purpose of continuing care, the following information related to the above patient:

(______)Entire medical chart

(______)Core chart (to include: last one year of progress notes, clinical correspondence and consultations, Problem List, Medication List, last Physical Examination, lab, x-rays, immunization records, and most recent tests including EKG's.)

(______)Information related to the following condition, treatment or dates of service:
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I understand that this may include the release of FEDERALLY PROTECTED INFORMATION pertaining to the testing, diagnosis and/or treatment of conditions such as psychiatric or mental health problems, alcohol or drug use, sexually transmitted diseases or HIV/AIDS, if relevant. Please **EXCLUDE** from the records released information related to:
____Drug/alcohol ____Sexually Transmitted Disease ____HIV/AIDS ____Mental Health

MY RIGHTS: I understand I do not have to sign this in order to receive health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization 1) to take part in a research study, or 2) to receive health care when the purpose is to create information for a third party. I may revoke this authorization in writing, per the Privacy Notice I have received. I understand that some information may be re-disclosed to a third party where allowed by law.

____ _______/_______/______
Signature of patient or representative **Date signed**

____
Relationship **Interpreter**

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This consent expires 90 days from the date signed