CLINE FAMILY MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____ DOB: _____ Phone#_____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone#_____ Fax#_____

PLEASE SEND INFORMATION TO:

CLINE FAMILY MEDICINE

I AUTHORIZE the following information to be disclosed: (please initial all that apply)

_____ Entire Record
_____HIV Record
_____Billing Records
_____Immunization Records
_____STD Record
_____Other
_____Lab Test
_____Psychiatric/Mental Health
_____TB Test
_____Alcohol/Substance Use

REASON for disclosure of health information: (please initial)

_____At my request
_____Job
_____Other
_____Continuing
_____School
_____Legal
_____Insurance

EXPIRATION of this Authorization: (please initial)

_____ 90 days after signature date_____ on this date_____

_____When this event happens: _____

ADDITIONAL PAYMENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below +
- I understand that I do not have to sign this authorization to get treatment
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws

_____ Date: _____
Client Signature (Parent or Legal Representative, if applicable) Relationship/Authority
+ I wish to withdraw this authorization: _____Date:_____