Poronsky Family Practice, Ltd.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____ / _____ / _____

Social Security Number: _____ - _____ - _____ Patient's phone number: (_____) _____

Date of Request: _____ Date Needed: _____

AUTHORIZATION

☐ **I authorize Poronsky Family Practice, LTD to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

(_____)_____ (_____)_____
Phone Number Fax Number

☐ **I authorize Poronsky Family Practice, LTD to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

(_____)_____ (_____)_____
Phone Number Fax Number

RECORDS REQUESTED:

I authorize the release of any and all information or records concerning my mental and physical history, diagnosis, treatment, prognosis, examination, advice or care provided to me.

This information includes but is not limited to records regarding mental health diagnosis and treatment, use of drugs, use of alcohol, acquired immune defiency syndrome (AIDS) or Aids-related-complex (ARC).

AUTHORIZATION VALID FOR: *(Check one.)*

☐ This request only.

☐ One year from the date of this authorization OR _____(Insert date.) *This authorization applies to the records of the treatment received on or prior to the date of this authorization.*

☐ This request and for medical records of any future treatment of the type described above until: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the bottom of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of full records, including mental health related care, or substance abuse diagnosis and treatment information
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ **Date** _____

Relationship to Patient (if requester is not the patient) _____

** Please allow at least two weeks from date received, for records to be faxed or mailed.*