

MACKEY FAMILY PRACTICE, P.A.

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Authorization To Disclose Health Information & Release Record

1. **Regarding Patient:** Medical Record Number: _____

Last Name First Name MI

Street Address

City State Zip Code

Date of Birth Phone

2. **Information Released From:**

Name (Health Care Provider)

Street Address

City State Zip

Phone

3. **Information Released To:**

Name (Health Care Provider)

Street Address

City State Zip

Phone

4. **This information shall include the following:**

Date(s) of service to release: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Emergency Report |
| <input type="checkbox"/> Progress/Office Notes | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Nursing Notes |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> ECG/EEG/Cardiac Cath | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Other (Specify) _____ | | |

5. **NOTICE:** This authorization is for FULL DISCLOSURE OF ALL RECORDS, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.
Exclusions: _____

6. **Purpose for Disclosure:**

- | | | |
|--|---|--|
| <input type="checkbox"/> Continuing Treatment | <input type="checkbox"/> Insurance | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Other (Specify) _____ | | |

7. **RESTRICTIONS:** I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

8. I hereby authorize disclosure of the health information to the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification, but that it will not have any effect on information released prior to notification of cancellation.

Signature of Patient/Legal Authority: _____ Date: _____

Legal Authority is: Guardian Parent of Minor Attorney in Fact
 Next of Kin Executor of Estate Other _____

Patient is: Minor Incompetent Disabled Deceased

Documentation of legal status must be attached.

Health Information Released By:

Name Title Date