TLC FAMILY HEALTH

Medical Records Release Authorization

I hereby authorize _____ (medical facility) to release my individually identifiable health information as outlined below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory and imaging reports, medical history, treatment, and any other such related information. I understand that this authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

_____ _____ _____

Patient name (please print) Date of birth Phone number

_____

Address (including City, ST, and zip code)

Information to be released:

◯ Complete records from _____ to _____, including lab and imaging reports

◯ All vaccinations ◯ All preventive measures (colonoscopies, mammograms, paps, etc.)

◯ Other _____

Purpose of releasing records (circle): Transfer of care (or _____)

Please release the above information to Douglas M. Cluff, M.D. at TLC Family Health (address and numbers below)

_____ _____

Signature Date

_____

Patient Name (printed)

Circle: Self / Other: _____

Relationship to Patient (legal authority if minor, attach supporting documentation)