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Authorization to Release or Obtain Health Care Information

Patient Name:	Birth Date:
Address:	Phone:

I hereby authorize Rebecca Farinas, MD to request or release the medical information about me indicated below to the following person or entity:

Name:	
Phone:	Fax:
Documents Needed (If any):	

Purpose of Release:

- ❑ Continued Care
- ❑ Collaboration
- ❑ Requesting Specific Records
- ❑ Insurance
- ❑ Disability
- ❑ Legal
- ❑ Personal
- ❑ Other:_____

If for continued care, records are needed for doctor's appointment on: _____

I am aware that my records may contain information related to mental health, substance abuse and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.

I understand that this authorization will expire in one (1) year, but I may revoke it at any time in writing. I understand that any such revocation will not apply to any information already released under this Authorization. I understand that the practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form.

I understand that once the above information is disclosed, the recipient may re-disclose it, however, information may not be protected by federal law or regulations.

By signing below, I authorize Rebecca Farinas, MD to release or obtain medical information about me as described above.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Relationship to Patient (if applicable)