



Henry County Family Physicians Inc.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, _____/_____/_____, authorize
Print First Middle Initial Maiden Last Date of Birth

_____ Dr. Bidwell _____ Dr. Fritz _____ Dr. Knipe _____ Dr. McMaster _____ Julie Thomas, CNP
at Henry County Family Physicians to release the following PHI from _____ to _____
Date Date

- | | |
|--------------------------|---------------------|
| _____ All Records | _____ Lab Reports |
| _____ Office Visit Notes | _____ X-Ray Reports |
| _____ Hospital Reports | _____ Other _____ |

Records to be Released TO: _____
PHYSICIAN'S NAME

ADDRESS

CITY STATE ZIP

PHONE NUMBER FAX NUMBER

Release for the Purpose of: _____ Continued Care _____ Transfer of Care
 _____ Moving Out of Area _____ Change of Insurance
 _____ Specialist Consultation _____ Other _____

Consent:

I authorize the release of all information indicated, and I am aware that the records release may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol use/abuse, HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome). This authorization is valid for 90 days. It may be revoked by the signer. I understand that I am responsible for any charges associated with copying these records. I understand that it may take up to 10 business days to complete the record transfer. The use of this information for any other use than the stated purpose is prohibited. This information is for the use of the designated recipient only and cannot be provided to any other agency.

Signature of Patient, Parent, Guardian, or Patient Representative (circle one):

_____ Date: _____

Witness Signature: _____ Date: _____