Your Choice Medical, llc
Internal Medicine

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

(please print clearly)

Patient name: ______________________________ Patient date of birth: ______________

I hereby authorize to release protected health information:

From

Name: ______________________________

Address: ______________________________

____

Phone: ______________________ Fax: ______________________

To

Name: ______________________________

Address: ______________________________

____

Phone: ______________________ Fax: ______________________

For the purpose of *(check one)*:

❏ Transfer of care to a new primary care ❏ Consultation of specialist

Other *(please specify)*: ______________________________

Extent of authorization

❏ I authorize the release of my complete health record (**including** records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

❏ I authorize the release of my complete health records with the **exception** of the following information:

❏ Mental health records ❏ Communicable diseases (including HIV and AIDS) ❏ Alcohol/drug abuse treatment

❏ Other *(please specify)*: ______________________________

This authorization shall be in force and effect until ______________ *(date)* at which time this authorization expires.

I understand that I may revoke this authorization at any time by notifying Your Choice Medical, llc in writing, however such revocation does not affect any actions taken on this authorization before receipt of said revocation.

I understand that information used or disclosed pursuant to this authorization could be subject to be redisclosed by a recipient and, if so, may not be subject to Federal or State law protecting its confidentiality.

I understand that I may inspect or copy protected health information described by this authorization.

Signature: ______________________________ Date: ______________

Patient signature or patient represenive: ______________________ Date: ______________

Printed name of above signature: ______________________________