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Eureka Family Practice

An Incorporate Medical Group
Lorraine Gomes Privacy Officer

Authorization for Records Release

Under federal and state law practice may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practice. Your completion of this form means that you are giving permission for the uses and disclosure described below.
I hereby authorize this medical practice to use and disclose health information concerning

_____

(Patient Name) **(Date of Birth)** **(Social Security #)**

- **Standard Release:** Problem list, medication list, immunization records, last two years of chart notes and laboratory results and last 5 years of EKGs and Radiology reports.(HIV test may be included in lab reports (**Y** or **N**)
- **The Complete Medical Record** in your possession concerning illness and/or treatment, including any psychiatric condition and alcohol/substance abuse records.(HIV test may be included in lab reports (**Y** or **N**)
- **Only the following information**:_____

_____

Purpose of use or disclosure:_____

Records Released From: _____

_____

Records Released To: _____

_____

I understand that I have the right to receive a copy of this authorization and that I may revoke at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. **I also understand that I will be billed .25 per Page for all records copied and processing can take 7 to 10 business days.**

Sign:_____ **Date**:_____
Print Name:_____
This authorization is to be in effect for One Year following this date signed.
If not signed by the patient please indicate relationship:_____

- Patient or Guardian of minor patient.
- Guardian or Conservator of an incompetent patient (**Documentation will be required**)
- Beneficiary or personal representative of deceased patient.(**Documentation will be required**)

Name of Patient:_____