**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

arbor place
family medicine

**PLEASE COMPLETE TO HAVE YOUR RECORDS COPIED**

PATIENT NAME: _____
LAST FIRST MI MAIDEN

DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____
CITY STATE ZIP CODE

I AUTHORIZE _____ TO RELEASE MY PROTECTED HEALTH INFORMATION TO ARBOR PLACE FAMILY MEDICINE P.C.

PURPOSE OF DISCLOSURE: _____
(EXAMPLE: CONTINUUM OF CARE, RELOCATION, ETC.)

**INFORMATION TO BE RELEASED:**

- ***MEDICATION LIST, PROBLEM LIST, IMMUNIZATION FORM, DIABETIC/ HYPERTENSION FLOWSHEET**
- ***OFFICE NOTES FOR ONE LAST YEAR**
- ***MOST RECENT EKG, ECHO, EXCERCISE/NUCLEAR STRESS TEST**
- ***X-RAY REPORTS FOR THE ONE LAST YEAR**
- ***MOST RECENT SPIROGRAM/PFT/OXIMETRY**
- ***ANY DRUG/ALCOHOL, AIDS/HIV, STD, MENTAL HEALTH INFORMATION**
- ***OTHER**

**I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THIS DATE.**

**I UNDERSTAND THAT MY HEALTHCARE AND PAYMENT FOR MY HEALTHCARE WILL NOT BE AFFECTED IF I DO NOT SIGN THIS FORM AND THAT I MAY REFUSE TO SIGN IT.**

**I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITTEN NOTICE. THIS AUTHORIZATION WILL CEASE TO BE IN EFFECT ON THE SATE OF THIS NOTCIE EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ACTER IN TRUST UPON THIS AUTHORIZATION**

**I UNDERSTAND A CHARGE MAY BE INCURRED FOR ARBOR PLACE FAMILY MEDICINE P.C. TO COPY MY RECORDS**

_____
SIGNATURE DATE