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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ____ Date of Birth: ______________
(Please Print)

I do hereby, authorize the office of Larry Stonesifer, M.D., Marcia Miller, A.R.N.P., & Marjorie Sladek, A.R.N.P. to disclose my healthcare information.

MEDICAL RECORDS RELEASED TO:

____
Name of designated recipient

____
Address

____
City, State and Zip

(______)____________________ (______)____________________
Phone Fax

___ All healthcare information including records of testing and/or treatment for drug & alcohol dependence, psychiatric or mental health disorders, sexually transmitted disease including AIDS, or transsexualism.

___ I do **NOT** consent to the release of the following:
- ___ Sexually Transmitted Disease ___ HIV Testing results or Treatment
- ___ Substance Abuse (Alcohol/Drug)
- ___ Transsexualism ___ Mental Health or Psychiatric Disorders

___ Other: ____

Purpose for which disclosure is being made: (please check one of the following.)

___ Attorney ___ Insurance ___ Doctor ___ Personal

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, and enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the privacy notice to our patients. I understand that once the above named facility discloses health information, the person or organization that received it may re-disclose it, at which time it may no longer be protected under privacy laws. If you desire a copy of this authorization, please notify a representative of the medical records department upon completion of this form

SIGNATURE: ____ DATE: _________________________

Please provide documents to prove authority to sign on behalf of the patient. This authorization will expire 90 days from the date signed. Please be aware that medical record copy fees may apply and contacting your former healthcare provider for specific medical record processing details is recommended.