CENTRAL PRIMARY CARE
INTERNAL MEDICINE
Taking Care of Families

Central Primary Care
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____
Date of Birth: _____
Phone #: _____
Address: _____
City/State/ Zip Code: _____
Social Security #: _____
Patients or Guardians Signature: _____
If person giving authorization is different from the patient, indicate legal basis on which consent is given:
_____

MEDICAL INFORMATION RELEASED TO:

Individual/Organization: _____
_____
_____
Address: _____
_____
_____
City, State, Zip: _____
_____
Phone #: _____
Fax #: _____

MEDICAL INFORMATION REQUESTED FROM:

_____
_____
_____
_____
_____
_____
_____
_____
_____

PURPOSE OF THE DISCLOSURE:

- ❑ Physician Change/Organization for Continuation of Care
- ❑ Personal Use
- ❑ Legal
- ❑ Other (Specify): _____

METHOD OF DELIVERY:

- ❑ By US Mail
- ❑ Pick up by the Patient or (Specify Individual).____

(A photo ID is required to pick up records)

INFORMATION REQUESTED:

- ❑ Abstract Only
  (Most Recent History & Physical, Discharge Summary, Operative Reports, Pathology Reports, Consultation Reports, Clinic Notes, Radiology Reports, Lab Reports)
- ❑ Entire Medical Record
- ❑ Other (Specify): _____

Expiration Notice: I understand that this consent is revocable any time prior the release of this information. This authorization will expire 90 days from the date signed. **RECORDS FROM OTHER FACILITIES/ REDISCLOSURE:** It is the policy of Central Primary Care to release only medical information documented or dictated by the physicians and his staff. If other health care providers have treated you, please contact them and make arrangements to release any information you may need. Federal Regulations prohibit us from re disclosing information without the specific written consent of the person to whom it pertains.

ANY FEES INVOLVED IN THE TRANSFER OF THE RECORDS TO CENTRAL PRIMARY CARE FROM A PREVIOUS PHYSICIAN OR FROM CENTRAL PRIMARY CARE TO ANOTHER FACILITY IS THE RESPONISBILITY OF THE PATIENTS.