Sunshine
FAMILY MEDICINE

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Laura Jones MD
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Authorization for Release of Information to: _____

Patient Name:_____ **Birth date**:_____

I hereby give my permission to : _____
Name of Facility/Provider/Individual/Organization

_____
Address City State Zip

By initialing the space below, I authorize the disclosure of the following health information and/or records, if such information and/or records exist:

_____ Entire Medical Record

_____ Most recent Five-year History

_____ Clinician Office Chart Notes

_____ Other: _____

_____ Laboratory Reports

_____ Pathology Reports

_____ Diagnostic Imaging Reports

I also specifically request the following information to be released. (This information will not be released unless initialed.)

_____ Drug/Alcohol Diagnosis, Treatment, and/or referral information.

_____ Mental Health Information

_____ HIV/AIDS Related Health Information

I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.

Signature of Patient::_____ Date:_____

Signature of Guardian:_____ Date: _____

Signature of Witness: _____ Date:_____

To Receiving Agency: Prohibition of Redisclosure

This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information.