

Medical Records Release To:

HonorHealth Medical Group

I authorize the following physician/facility to disclose information from my health record:

Physician Name Facility:

Address: City State Zip

Phone Number: Fax Number:

PATIENT IDENTIFICATION, INFORMATION REQUESTED, INFORMATION TO BE SENT TO. Includes fields for Patient Name, Date of Birth, Address, City, State, Zip, Phone Number, Dates of Service, and checkboxes for Office Visit Note(s), Laboratory Results, EKG Report, History & Physical, Pathology Report, X-Ray Reports, Billing Record, and Other.

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that the practice will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. The John C. Lincoln Physician Network Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that I may receive a copy of this authorization.

Unless I revoke this authorization earlier, it will expire one year from the date signed or as specified:

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release the practice, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Legal Representative

Relationship to Patient or Description of Authority to Act for Patient

For Healthcare Use Only. Date Received: Date Sent: Processor: PN 200