NEWLAND MEDICAL ASSOCIATES, P.C.

# Authorization to Release Patient Health Information

Patient Name: _____ Date Of Birth: _____

Patient Address: _____
(Street) (City, State, Zip Code)

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I hereby authorize: _____
(Name of physician, institution, clinic sending records)

_____
Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

To release patient health information to:

Name of Facility:

Contact person/title:

Address of facility: _____
Street City, State, Zip Code

Phone Number: _____Fax Number:_____

**Information to be released: (check all that apply)** From: _____ to _____
(dd/mm/yy) (dd/mm/yy)

____ Progress Notes ____ Outpatient Test Reports ____ Inpatient Test Results
____ Laboratory Tests ____ Radiology Reports ____ Operative Report
____ All of the Above

*Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS or mental health will be disclosed:*

**Yes,** disclose this information: _____

**No**, do not disclose this information: _____

**Purpose of this Release is:**

_____Continuity of Care _____Requested by Patient/Patient Representative _____Other:

_____

**NOTICE**

Newland Medical Associates, and many other organizations and individuals such as hospitals, physicians and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Newland Medical Associates. The revocation will take effect when Newland Medical Associates, receives it, except to the extent that Newland Medical Associates or others have already relied on it.

I am entitled to receive a copy of this authorization.

**EXPIRATION OF AUTHORIZATION** (may be a specific date or condition. If left blank, the authorization will expire 6 months from date below)

This authorization expires _____/_____/_____
(mm) (dd) (yyyy)

_____ Date: _____
(Signature of Patient or Patient's Legal Representative)

_____ Time: _____AM/PM (Printed Name)

_____
(If signed by someone other than the patient, state your legal relationship to the patient)

_____
(Witness or Translator)

***Authorizations signed by a legal representative must include a copy of the guardianship papers or a court certified power of attorney/personal representative document.***