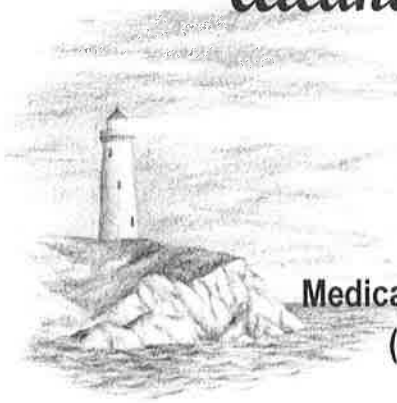
Atlantic Family Physicians



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Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize medical information to be released. Please initial all that apply:
[ ] Office Notes [ ] Claim/ Billing Information [ ] Laboratory Testing
[ ] Diagnostic Imagining Results [ ] Medication List [ ] **All Medical Information**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

[ ] Information is not to be released to anyone.

Expiration of this Authorization: Valid for a period of ten (10) years from the date signed, unless earlier revoked in writing by me. I understand that I have the right to revoke this Authorization by way of delivering a signed and dated Revocation of Authorization to the healthcare provider named above, but that this authorization can be revoked as to Protected Health Information which has been previously released in reliance on this document.
Voluntaries: I voluntarily signed this Authorization and acknowledge I am aware that my refusal to sign this authorization will not result in denial of health care by any hospital or health care provider. This authorization has not been coerced by any health care entity or any of its business associates.
Any fax and/or copy of this authorization shall be treated as the original document.

Signature: _____ Date: _____

Printed Name: _____

Witness: _____ Date: _____