

LIBERTY FAMILY MEDICINE LLC



7136 Office Park Drive>West Chester, OH 45069>513-755-1912 phone>513-755-2013 fax

Patient Authorization for use and disclosure of Protected Health Information

By signing this authorization, I authorize the disclosure of the following protected health information (PHI). This includes a release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, and/or psychiatric/psychological conditions.

- | | | |
|--|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Educational Records | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Medications Prescribed | <input type="checkbox"/> Lab Results/Imaging Reports |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Mental Health/Substance Abuse Records | <input type="checkbox"/> Other (specify below) |

The above information is to be disclosed To:

Name _____
Address _____
City,State,Zip _____

From:

Name _____
Address _____
City,State,Zip _____

Reason for Disclosure:

- Transfer to New Physician-If so, Why? _____
- Seeing Specialist-If so, which doctor? _____
- Insurance
- Legal
- Other (specify) _____

This statement must be signed and dated, and may be revoked at any time except to the extent of action that has been taken prior to revocation. This consent will expire one (1) year after the date below, or sooner by my choice, in which case this consent will expire on _____.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I do not have to sign this authorization in order to receive treatment from Liberty Family Medicine LLC.

I hereby state that I have read and fully understand the above statement as they apply to me. I hereby authorize and consent to the disclosure of the treatment records for the purpose and extend stated above.

Patient's Name _____
Address _____
City,State,Zip _____
Birth Date _____ Phone _____
Signature _____ Date _____

If not patient signing, please print name and relationship to patient below:
