AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

NAME OF PATIENT/ PREVIOUS NAMES	PHONE NUMBER	FAX NUMBER

I AUTHORIZE:

Argyll Medical Group

NAME OF PERSON/ FACILITY WHICH HAS INFORMATION	PHONE NUMBER

TO RELEASE HEALTH INFORMATION TO:

SPECIFY NAME/ FACILITY TO RECIEVE	PHONE NUMBER	FAX NUMBER

INFORMATION TO BE RELEASED: (ENTIRE RECORD) _____ OR:

- ☐ Medical History, Examinations, Reports
- ☐ Immunizations
- ☐ Prescriptions
- ☐ Laboratory Reports
- ☐ Imaging Reports
- ☐ Allergy Records

For the reason below which require special permission to release otherwise privileged information, please release records pertaining to:

- ☐ Mental Health
- ☐ HIV/AIDS
- ☐ Other:
- ☐ Developmental Disabilities
- ☐ Sexually Transmitted Disease
- ☐ Alcoholism
- ☐ Drug Abuse

PURPOSE FOR NEED OF DISCLOSURE: (CIRCLE ALL THAT APPLY)

(Further Medical Care)	Personal	Insurance eligibility/benefits	(Changing physicians)	Other:

This authorization is good until the following: ___Until Revoked_____

I understand that I can revoke this authorization at any time by writing Argyll Medical Group LLC, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I understand I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal. Federal privacy regulations will no longer apply to the information disclosed, and that Argyll Medical Group LLC, may re disclose the information. I am entitled to receive a copy of the authorization. A copy of this authorization may be utilized with the same effectiveness as the original. I have had an opportunity to review and understand the content of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Representative	DATE:

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