Wills Valley Family Medicine

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

____________ I DO NOT wish to have test results or other medical information released to any person other than myself.

____________ I DO wish to have test results or other medical information released to the following person(s):

Name:__________________ Relationship: ________________

Name:__________________ Relationship: ________________

Name:__________________ Relationship: ________________

Name:__________________ Relationship: ________________

It is the responsibility of the patient to notify this office of any changes in the above information. If changes to occur, the patient must file another Authorization for Release of Patient Information with this clinic.

Please understand that it may be necessary for us to disclose some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers. At times, other providers assist us in assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information released to your employer, other than information needed to verify your insurance coverage, the data will consist of statistical information only.

Patient Signature:______________________________ Date: ________________

Printed Name: __________________________________ SS#: ____/____/_____