AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Releasing information to Family Members / Power of Attorney

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone #: _____
City/State/ZIP: _____ _____

I authorize Montgomery Medical Associates, PC to release patient records to:
Name of Individual: _____Relation: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone:_____

Signatures

- I understand that I have the right to revoke this authorization at any time. I understand the revocation must be in writing and must be sent to the attention of Medical Records at Montgomery Medical Associates, PC. The revocation will not apply to the extent that DMG has already taken action in reliance on the authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by law.
- I understand I have the right to inspect and/or receive a copy of the medical information to be used or disclosed and also receive a copy of this authorization form.
- I understand I have the right to refuse to sign this authorization and Montgomery Medical Associates, PC does not condition treatment on the provision of the authorization for the requested use of disclosure, except disclosure necessary to determine payment of claim (excluding authorization for the use or disclosure of psychotherapy notes); or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF RECORDS FOR THE PURPOSE STATED ABOVE.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Parent/Guardian or Representative Relationship to Patient Date
(Generally required if patient is under 18 yrs old or incompetent.)

_____ _____
Signature of Witness Date