LivingWell Primary Care
...We Focus on Prevention

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PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____

Dr. Rochelle Collins is authorized to furnish to/receive from (circle desired choice)

Recipient/Discloser: _____

For the purpose of: _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

◯ ***I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS*** including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assault, abortion, illegitimacy of birth, communications to social workers and/or psychotherapists, psychologist, if any.
◯ ***I GIVE PERMISSION TO RELEASE ONLY THE RECORDS*** specifically described below:

_____

_____

I release Rochelle L. Collins, DO LLC, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Rochelle L. Collins, DO LLC, provided that I do so in writing and to the extent that you have already disclosed the information on reliance on this authorization.

This authorization expires on _____/_____/_____ (Optional). If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

_____ _____
Patient Signature (Patient's Representative, if minor) Date

_____ _____
Witness Signature Date