Family Medicine of SayeBrook

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ACCT#: _____

AUTHORIZATION TO RELEASE INFORMATION FROM FAMILY MEDICINE OF SAYEBROOK, LLC

I,_____,_____
(name) (date of birth)
_____ hereby authorize release of my medical
(social security number)
records from Family Medicine of SayeBrook, LLC to:

Physician or Medical Facility _____
Address _____
Phone_____Fax _____

Description of the information to be released: (check all that apply)

_____ Labs
_____ Medical Record 1 year
_____ Other: _____

- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations.
- I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
- I understand that I may revoke or terminate this authorization by submitting a written revocation to Family Medicine of SayeBrook, LLC.

Patient (or patient representative) Signature:_____Date: _____
This authorization shall be in effect for one year from date signed.

Relationship of patient representative to patient: _____

Witness Signature: _____