Patient Authorization to Release Medical Records/Disclose Protected Health Information

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Patient Name_____

Patient Date of Birth_____/_____/_____ **Patient SSN** _____

Name of Individual Requesting Release_____

Relationship to Patient:
- ☐ Self
- ☐ Parent/Guardian of minor
- ☐ Legal Counsel – Provide copy of legal representation document
- ☐ Other – specify:

Purpose of the Release: At the Request of the Patient

I hereby authorize American Family Care to release any medical records and/or medical information to the following individual(s):

1. Name_____

   Address_____
2. Name_____

   Address_____
3. Name_____

   Address_____

I understand that, in compliance with Privacy Act regulations (45 CFR 164.508(c)),

- I request and authorize release of medical records and/or medical information to the above named party(s).
- This release is voluntary and I have the right to revoke this authorization at any time. My revocation must be in writing and provided to American Family Care.
- I may refuse to sign this authorization and such refusal will not affect my treatment.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information.
- I have a right to a signed copy of this authorization.

This authorization shall expire on _____/_____/_____**.** If no date is provided, this authorization will expire one year from the date of signature/authorization indicated below.

_____ _____

Patient Signature **Date of Signature/Authorization**