

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize **PrimeCare Medical, Inc.** at the \_\_\_\_\_ (facility) to  
release copies of the portions of my health records described below to \_\_\_\_\_,  
for the following purposes: \_\_\_\_\_  
\_\_\_\_\_

**Specific Information Covered by this Authorization**

*THE FOLLOWING INFORMATION IS SPECIALLY  
PROTECTED BY FEDERAL AND STATE LAWS. IF ANY  
OF THIS INFORMATION APPLIES TO YOU, PLEASE  
INDICATE ANY OR ALL OF THE INFORMATION YOU  
WOULD LIKE TO MAKE SUBJECT TO THIS  
AUTHORIZATION:*

( ) Alcohol/Drug Abuse Records    **\*\* Additional Form  
Required (H-RR2)\*\***  
( ) Mental Health Records        \_\_\_\_\_ Initials  
( ) HIV Related Info.                \_\_\_\_\_ Initials

( ) Discharge Summary        \_\_\_\_\_ Initials  
( ) History/Physical Info.      \_\_\_\_\_ Initials  
( ) Laboratory Studies        \_\_\_\_\_ Initials  
( ) X-ray Reports                \_\_\_\_\_ Initials  
( ) Operative Reports        \_\_\_\_\_ Initials  
( ) Pathology Reports        \_\_\_\_\_ Initials

Date(s) of Service and/or medical  
Information specific to this request: \_\_\_\_\_  
\_\_\_\_\_

This Authorization will expire one (1) year from the date that I sign it. I understand that I may revoke this Authorization, in writing, at any time. I also understand that my revocation of this Authorization will not impact any action taken in reliance on this Authorization prior to PrimeCare Medical's receipt of my written revocation.

I understand that my treatment may not be conditioned on my agreement to sign this Authorization. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the persons listed above and may no longer be protected.

I understand the nature of this Authorization.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

**If the above signatory is a personal representative, their legal relationship to the patient/client is:** \_\_\_\_\_  
\_\_\_\_\_

Signature of staff person obtaining authorization: \_\_\_\_\_

**If this Authorization authorizes the release of Mental Health Records or HIV-related information, the following statement must be included with the information being released:**

This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws. These laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the patient to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.