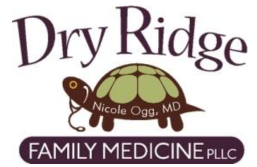
Authorization for Release of Patient Information

to entity other than the patient



Please indicate who Dr. Ogg or her staff may speak with about medical or financial information pertaining to you, or if our office may leave detailed messages about lab results or other medical or financial matters on your answering machine.

Patient Name ____

Patient Date of Birth ____

Dry Ridge Family Medicine is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Who Can Receive Information Check each person/entity that you approve to receive information.	**Description of information To Be Released** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail/Answering Machine	☐ Results of lab tests/x-rays ☐ Other ______________________
☐ Spouse	☐ Financial ☐ Medical as follows: ________________ ______________________________
☐ Parent (provide name) ______________________________ ______________________________	☐ Financial ☐ Medical as follows: ________________ ______________________________
☐ Other (provide name) ______________________________ ______________________________	☐ Financial ☐ Medical as follows: ________________ ______________________________
☐ Only Me	

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ ____________________

Signature of Patient or Personal Representative Date

If a personal representative of the patient signs this form, please provide a description of personal representative's authority and attach necessary documentation

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