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Authorization to Release Health Care Information

Patient Name: ____

Date of Birth: ______________________________ Patient Phone: ________________________________

Address: __________________________________ City ______________________ ST, ZIP ___________

I authorize and/or request Trinity Doctors Group, P.A. to:

☐ Release my information to:
☐ Obtain health care information from:

Name: ______________________________ Name: ______________________________

Phone: ______________________________ Phone: ______________________________

Fax: ______________________________ Fax: ______________________________

You are authorized to disclose or receive the following:

☐ History & Physical ☐ Consultations ☐ Discharge Summary ☐ Operative Notes ☐ Labs, Imaging ☐ Office Notes

☐ Other: ____

Specify dates of records needed: ____

I DO ☐ I DO NOT ☐ authorize the release of information relating to the diagnosis of treatment of alcohol or drug abuse. If I authorize release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.

I DO ☐ I DO NOT☐ authorize the release of information relating to the diagnosis or treatment of mental health. If I authorize the release of this information, I DO ☐ I DO NOT ☐ want to review this information before it is released. I understand that my review must be supervised. I understand that release of information may be necessary for reimbursement and that I may decide to pay for services myself rather than allow release of my information.

I DO ☐ I DO NOT ☐ authorize the release of information relating to the diagnosis or treatment of HIV, ARC, or AIDS.

☐ This authorization is effective for 1 year from the date below and I authorize future disclosures to the same individuals and or entities during this time period.
I understand that:
I can revoke all or part of this authorization at any time by notifying Trinity Doctors Group, P.A., as provided for in our Notice of Privacy Practices, subject to the rights of anyone who received disclosed information prior to receiving my revocation.
I can refuse to disclose all or some of the information in my health care records.
A refusal to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for your health benefits and other adverse consequences.
The information released may be subject to re-disclosure unless otherwise protected by law. I may cross out any words on this form with which I disagree.

Signed: ____ Date: ____________________
(Patient or his/her legally appointed representative)