PLEASE COMPLETE ALL AREAS MARKED WITH AN *ASTERISK*

For any questions regarding this form,
Please contact our Medical Record Coordinator:
Sonya (910) 383-1500

Authorization to Disclose Health or Billing Information

PATIENT INFORMATION	Medical Record #	***Date of Birth**
***Patient Name**	***Patient Address**	
Patient Nickname/Maiden Name		

I give permission to:	To release information to:
Name of Person/Facility	Name of Person/Facility
City/State/Zip	City/State/Zip
Phone # Fax #	Phone # Fax #

Check information to release

☐ Name	☐ History & Physical	☐ Nurses Notes
☐ Address	☐ Laboratory Report	☐ Operative Report
☐ Phone Number	☐ Radiology Report	☐ Medication Records
☐ Insurance	☐ Radiology Images	☐ Progress Notes
☐ Social Security #	☐ Consultations	☐ Discharge Summary
☐ Entire Medical Record		

☐ Other (Describe) ____________________

Treatment dates (if certain dates are wanted)

This is a full release including all drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:

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Check reason for release ☐ Patient Request ☐ Workers' Compensation ☐ Disability ☐ Treatment ☐ Insurance ☐ Other (Describe) ____________________

Release Information ☐ In-person ☐ Pick-up ☐ Fax ☐ Mail ☐ Other (Describe) ____________________

1. By law, Batish Family Medicine can't use or share my health information without my permission except by ways listed in Batish Family Medicine's notice of Privacy Policies.
2. I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I can't cancel consent for information already shared as a result of this permission.
3. I don't have to sign this form. Refusal won't change my ability to get treatment, payment for treatment or benefits
4. Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.
5. I have read, understand and been given a copy of this form.
6. This is not for use for Marketing or Research.

NOTICE: I may be charged to copy or mail this information.

Authorization expires 90 days after I sign it unless a date or an event is written here:

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***Patient/Patient Representative Signature** ____________________ Date____________

Legal Authority to sign for patient: ☐ Guardian ☐ Administrator/Executor ☐ Attorney in Fact ☐ Parent ☐ Next of Kin ☐ Other (Specify) ____________________

Patient is

Witness ____________________ Date ____________

If limited English proficient or hard of hearing, offer interpreter at no extra cost:

Interpreter: ☐ Accepted ☐ Refused ____________________