CREDO
FAMILY MEDICINE

Medical Records Release Form

Name: _____

Patient Account No.: _____

Date of Birth: _____/_____/_____

I, _____, hereby grant permission for Credo Family Medicine to disclose, in complete form, my medical records to the parties listed below. By signing this authorization I understand that this release includes all protected health information including any information pertaining to: substance abuse, sexually transmitted diseases, HIV/AIDS, and treatment for psychiatric disorders.

- I am aware there is no requirement to sign this authorization form in order to receive treatment from Credo Family Medicine.
- If this authorization is exercised, I am aware that any protected health information disclosed to the authorized parties listed below will no longer be protected under the privacy obligations of Credo Family Medicine as the actions of these parties are beyond our control.
- I am aware that I may revoke this authorization at any time by providing a signed written request to Credo Family Medicine.

Please fill in the appropriate fields below:

Relative/Representative: _____

Relationship/Role: _____ Phone Number: (_____)_____

Relative/Representative: _____

Relationship/Role: _____ Phone Number: (_____)_____

Relative/Representative:_____

Relationship/Role: _____ Phone Number: (_____)_____

Date: _____/_____/_____

Patient/Guardian Signature: _____

Printed Name: _____

Relationship to Patient: _____