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PATIENT NAME IN FULL

M

AGE

DATE OF BIRTH

F

SOCIAL SECURITY NUMBER

TELEPHONE NUMBER

I HEREBY AUTHORIZE CASTLEROCK PHYSICIANS AND ITS AGENTS AND EMPLOYEES TO RELEASE OR OBTAIN INFORMATION AND COPIES OF RECORDS PERTAINING TO MY MEDICAL CARE AND TREATMENT, WHICH COULD INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE, MENTAL HEALTH, OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.

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- PHYSICIAN
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- DISABILITY
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RELEASE MY MEDICAL RECORDS TO:

OBTAIN MY MEDICAL RECORDS FROM:

THE INFORMATION AUTHORIZED FOR RELEASE MY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHLSIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

DRUG/ALCOHOL ABUSE TREATMENT RECORDS: THIS CATEGORY OF MEDICAL INFORMATION/RECORDS IS PROTECTED BY federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Release: I release Castlerock Diagnostic Physicians and its agents and employees from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

PATIENT SIGNATURE

DATE

PERSON AUTHORIZED TO SIGN FOR PATIENT – SIGNATURE

DATE

REASON PATIENT UNABLE TO SIGN