Carl A. Willeford Jr. MSN, FNP-C
Family Nurse Practitioner

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Consent to Release Medical Information

I, _____, do hereby authorize the release for the following records and/or information with limitations, which may include treatment of psychiatric illness, alcohol or drug abuse, HIV test results or AIDS/ARC diagnosis, and/or sexual preference. Review of the record is also authorized.

Patient Name: _____ DOB: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____/_____/_____ Home#: (_____) _____-_____ Cell#: (_____) _____-_____

Release information for the period of: From: _____/_____/_____ To: _____/_____/_____

Request records from: (Facility/Physician) _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____ **Attention: Medical Records**

Please release the following information for continuity of care:

_____ Complete Medical Records _____ Radiology Reports _____ History & Physical
_____ Pathology Reports _____ EKG Reports _____ Lab Reports
_____ Medication Records _____ Operative Reports _____ Progress Notes
_____Other: _____

Records to be released to: *(check one)* _____Nacogdoches Family Medicine **OR** _____Self

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient an is no longer protected by state and federal privacy laws. I understand that treatment at Nacogdoches Family Medicine will not be denied if I do not sign this authorization.
I understand that I may revoke this authorization at any time by submitting a notice in writing to the privacy officer at Nacogdoches Family Medicine. I cannot revoke this authorization to the extent that Nacogdoches Family Medicine has taken action in reliance on the authorization, or if the authorization is to permit disclosure of PHI to an insurance company, as a condition of obtaining coverage, to the extent that other law allows the insurer to contest claims or coverage.

Signature of Patient/Parent/Guardian: _____

Witness (required if patient is unable to sign): _____

Employee Witness: _____

Date: _____/_____/_____

This authorization will expire in 30 days from the date of signature or on (date):