

EMPOWER FAMILY MEDICINE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Previous Name: _____

I authorize:

to release healthcare information of the patient named above to:

Melissa Black M.D.
Empower Family Medicine
Fax: 888-213-8479

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information

Specifically:

Most recent provider progress notes, past ____ months

Health maintenance record

Hospital H&P, Specialist consult notes, and discharge summary

Lab reports

Imaging results including radiology report films in digital format

Cardiac testing results including stress test, nuclear imaging, EKG and echocardiogram

Surgical report, Operative Note, or Cardiac Catheterization note

Most recent physical, occupational and speech therapy note including swallow study

Procedure notes including endoscopy, nerve conduction study, pulmonary function study

Pathology reports

Other:

Yes No I authorize the release of my STD* results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

*Sexually Transmitted Disease (STD) includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Signature: _____ Date signed: _____