The Family Clinic
OF LYNN HAVEN

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Authorization to Release Medical Information Form

Patient:

Name _____ Account Number _____

Street Address _____ City, State, Zip _____

Date of Birth _____

Authorizes:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State Zip _____

To Release Protected Health Information To:

The Family Clinic
621 Florida Avenue
Lynn Haven, FL 32444

Information To Be Released:

____ Medical History, Examinations, Reports
____ Treatment or Tests
____ Allergy Records
____ Consultations
____ X-ray Reports
____ Entire Record
____ Sexually Transmitted Disease
____ Drug Abuse
____ Other (specify):_____

____ Surgical Reports
____ Hospital Records Including Reports
____ Laboratory Reports
____ Immunizations
____ Prescriptions
____ HIV (AIDS)
____ Alcoholism
____ Developmental Disabilities

For the following date(s): _____

Purpose of the Disclosure (check applicable categories):

____ Further Medical Care
____ Insurance Eligibility/Benefits
____ Personal
____ Other (specify):_____

____ Legal Investigation or Action
____ Changing Physicians

Patient's Signature_____ Date_____

Revised: 3/15/17