GracePointe Healthcare PLLC
Modern medicine the old fashioned way

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Authorization to Release Medical Information

Patient Name: _____

DOB: _____/_____/_____ Social Security #: _____-_____-_____

Persons / organizations PROVIDING the information:	Persons / organizations RECEIVING the information:
_____	_____
_____	_____
_____	_____
_____	_____

Specific description of information to be released, including date(s):

_____

_____

What is the reason for releasing this information?

_____

_____

I understand that I have the right to refuse to sign this and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions:

1. Refusal to sign this authorization ,if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment.
2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Patient initials: _____

I understand that this authorization will expire on the following date _____/_____/_____ or with the following event:_____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Patient initials: _____

_____ _____

Signature of patient or patient's representative Date