FULLER DIAGNOSTICS, LLC

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** ___/___/_____

I authorize FULLER DIAGNOSTICS, LLC to release information as stated below from the patient health information record:

Information to be Released From: _____

Information to be Released To: _____

Information to be Released via: ☐ Email ☐ Fax ☐ Mail

Email/Fax Number/ Mailing Address: _____

Information to be Released: _____

Dates of service for information requested:

Beginning: _____ thru _____

Purpose of Release:

☐ Continuing care ☐ Copies for own use ☐ Transfer to another provider

☐ Legal ☐ Coordination with School ☐ Other: _____

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time. I understand that once the information has been released according to the terms of this Authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This Authorization will expire one year from the date signed below unless another date or event is entered here _____.

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐Mental Health Treatment ☐Sexually Transmitted Diseases ☐AIDS/HIV Treatment

☐Alcohol/Drug Abuse Treatment

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

To be filled out by FULLER DIAGNOSTICS, LLC:

Date Records were released: _____

Signature of Employee: _____