SYMMETRY
FAMILY HEALTH
Sandra Brown, APRN, FNP-BC
2523 Fort Campbell Blvd
Hopkinsville KY, 42240
Ph: 270-885-9995
Fax: 833-450-6246

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please complete form below and return with a copy of a photo ID.

Medical Record # _____ Social Security # _____
Patient Name: _____ DOB: _____
Address: _____

I hereby authorize Sandra Brown, APRN with Symmetry Family Health to release/request my protected health information to be released as directed below.

FROM: _____
_____
_____

TO: Symmetry Family Health
2523 Fort Campbell Blvd, Hopkinsville KY 42240
Ph: 270-885-9995 Fax: 833-450-6246

This information is needed for the following purpose:
( ) Medical Care ( ) Insurance ( ) Legal ( ) Other (please specify) _____

Treatment Dates to be included: _____

Please check all applicable information request

( ) Complete Medical Record	( ) Face Sheet	( ) Encounter Notes	( ) Laboratory Reports
( ) Radiology Reports	( ) Discharge Summary	( ) Consultation Report	( ) Medication Reports
( ) Operative Reports	( ) EKG/ Cardiographics	( ) Other : _____	

If your record includes information protected by Federal Law (psychiatric, alcohol, HIV, drug abuse), a separate signature is required in order to release this information. By signing below, you authorize the release of this federally protected information:

_____
Individual Signature

~I request and authorize the above named health care provider to release the information specified to the organization, agency, or individual named on this request. I understand that I have a right to revoke this authorization at any time (45CFR16.506(b)(5). My revocation must be in writing in a letter. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
~I understand that I have a right to request restrictions to the information disclosed (CFR164.506(b)(4).
~I also understand that this authorization expires in 90 days from the date signed.
~The entity to whom this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of this information as authorized above.
~ I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

_____ _____
Signature of Individual Date Legal Representative Date

_____ _____
Signature of Witness Date Reason why individual can't sign
(45CFR164.508 (c)

The first copy of medical information is FREE! There is a charge for any additional copies. If records are requested to be mailed, the actual postage amount will also be charged.