Irwin Family Medicine
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Authorization for Disclosure of Health Information

1. I hereby authorize_____to disclose the following information form the health records of:
   Name of Provider

   Patient Name_____ Patient SS# (last 4 digits)_____
   Date of Birth_____ Covering the period(s) of healthcare:
   Address_____ From (date)_____
   _____ To (date)_____
   _Telephone_____

2. Information to be disclosed:
   - ___Complete health records
   - ___History and physical examination
   - ___Consultation reports
   - ___X-ray reports
   - ___Discharge summary
   - ___Progress notes
   - ___Laboratory tests
   - ____ Photographs, videotapes, digital or other images
   - ____Other (please specify)_____
     _____
     _____
     _____

3. I understand that this will include information relating to (Check if applicable):
   - ____Acquired immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection
   - ____Behavioral health service/psychiatric
   - ____Treatment for alcohol and/or drug abuse

4. This information is to be disclosed to _____for the purpose of:
   Provider
   - _____Second opinion; NO TREATMENT
   - _____Patient changing physician
   - _____Diabetic supplies

5. I understand this authorization may be revoked in writing at any time. Except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____
6. The facility, its employees, officers, and physicians are hereby released form any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

_____
Patient Signature Date

_____
Legal Representative Date

_____
Signature of Witness Date