Main Street Family Practice, P.C.

Dario L. Lizarraga, M.D., Catherine O'Neill, F.N.P.-C
Theresa Koppal, P.A.-C

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: AVAILABLE UPON REQUEST

This authorizes: _____ to release health care information of the patient named above to:

Name: Main Street Family Practice

Address: 660 S. Main Street; P.O. Box 2818

City: Florence State: AZ ZIP Code: 85132

Photocopies of information to be released:

☐ Health care information relating to the following treatment, condition, or dates:

_____

☐ All health care information

☐ Other: _____

I authorize the release of photocopies of the following medical records and/or x-ray films to Main Street Family Practice, its employees and /or agents. ☐ Yes ☐ No

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. ☐ Yes ☐ No

I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party. ☐ Yes ☐ No

I understand that: A) I must revoke my authorization in writing and may do so by completing and signing a revocation notice, available at this office. B) If I revoke my authorization, it will not affect any actions already taken by Main St. Family Practice up this authorization; and C) I may not be able to revoke this authorization if the purpose of it was to obtain insurance. ☐ Yes ☐ No

Main St. Family Practice has disclosed health information; the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to healthcare provided to me more than ninety days after the date of this authorization. This prohibition does not extend to insurance companies. ☐ Yes ☐ No

Patient/Guardian/POA Signature: _____ Date Signed: _____

Relationship to Patient:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.