FOX VALLEY FAMILY PHYSICIANS
PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize FOX VALLEY FAMILY PHYSICIANS to use or disclose the following information from my health records.

The types of information to be disclosed are as follows:

- ☐ History and physical examination
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Operative reports
- ☐ My medical records dated from _____ to _____
- ☐ Abstract (documents summarizing history)
- ☐ Diagnostic reports (labs, x-rays, etc)
- ☐ X-ray films
- ☐ Mammorgram films
- ☐ Other:_____

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- ☐ HIV / AIDS related health information/records
- ☐ Behavioral or mental health information/records
- ☐ Drug/alcohol diagnosis, treatment, referral information
- ☐ Genetic testing information/records

2. The information described above will be disclosed to:

Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Telephone: _____ Fax:_____

3. Purpose or need for information:
This authorization expires (date):_____. If not specified, this release will expire 1 year after the date of signature (date):_____.

_____

_____

_____

My authorization for disclosure of the information above expires:

- ☐ On _____
- ☐ Specify event: _____
- ☐ End of research _____

4. I understand that if the person or entity receiving my health information is not a health care provider or a health plan covered by federal privacy laws, my health information to be disclosed, as described above, may no longer be protected by these laws and may be re-disclosed.

5. I understand that I may refuse to sign this authorization form and that my refusal to sign this form will not affect my ability to obtain treatment or payment, or my eligibility for benefits. If the protected health information requested is to be used or disclosed for determining my eligibility for a health plan, my refusal to sign this authorization form may result in a denial of my application for benefits under the health plan.

6. I understand that I have the right to inspect or copy any of the information disclosed by this authorization.

7. I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that Fox Valley Family Physicians has already acted in reliance upon this authorization as shown by my signature below and as explained in the Notice of Privacy Practices.

8. I understand that Fox Valley Family Physicians and its employees are released from any legal responsibility or liability for disclosure of my protected health information as described above and as authorized by my signature below.

9. I understand that I will receive a copy of the signed authorization form.

_____

Print Name of Patient / Legal Representative — Patient Date of Birth

_____

Signature — Date