

Dear Sir or Madam,

Please complete the following form in order to have your medical record released from Walker Family Medicine to whomever you request. The form must be completed signed and mailed, faxed or hand delivered to Walker Family Medicine. For questions regarding the form please call or email.

Sincerely,

Dr. Dawn Walker,

Ph 520-766-5000

Fax 520-766-5001

mail@walkerfamilymedicine.com

WALKER FAMILY MEDICINE, PLC

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All my health information maintained by the above-named practice
(Circle includeor excludefor each of the following)
- Include or Exclude My health information related to drug abuse
Include or Exclude My health information related to alcohol abuse
Include or Exclude My health information related to HIV/AIDS
Include or Exclude My health information related to psychological or psychiatric conditions, including psychotherapy notes
- My health information relating to the following treatment or condition: _____
 My health information for the date(s): _____
 Other: _____

You may disclose this health information to:

Name (or title) and organization:

Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- At my request
Continuity of care with specialist
Transfer of care to new primary care physician
Moving
- Other (specify) _____

This authorization ends: on (date) _____

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization one must write a letter of revocation to Walker Family Medicine, PLC.

Once WFM, PLC discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)