AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Envision PHYSICIAN SERVICES

Patient's Full Name: Date of Birth: MM /DD /YYYY

Address: City: State: ZIP:

Phone:

At the request of the Individual, I_____do hereby authorize EMO Medical Care LLC, an Envision Physician Services entity to release:

Dates of _____

- ❑ ALL
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Progress Notes
- ❑ Operative Notes
- ❑ Pathology Reports
- ❑ Lab Reports
- ❑ Radiology Reports
- ❑ Emergency Reports
- ❑ Other

❑ I DO ❑ I DO NOT authorize the release of information related to AIDS or HIV infection, psychiatric care, and/or psychological assessment, and treatment for alcohol and/or drug use.

Information Release to:

Name of Company/Agency/Facility/Person

Address: City: State: ZIP:

Purpose of Disclosure:

- ❑ Referral to Specialist
- ❑ Insurance
- ❑ Workers' Comp
- ❑ Physician Change
- ❑ Legal Investigation
- ❑ Disability Determination
- ❑ Personal
- ❑ Continuing Care

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to the notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and it would then no longer be protected by federal regulations. I understand that EMO Medical Care LLC, an Envision Physician Services entity will not condition its treatment of me on whether or not I sign this Authorization.

Patient Signature **Date**