RELEASE OF MEDICAL INFORMATION

MyCatholicDoctor

Authorization to release FROM MyCatholicDoctor

Patient Name (First Name, Middle Initial, Last Name): _____

Date of Birth (MM/DD/YY): _____

I request and authorize MyCatholicDoctor, PLLC to release the below-marked healthcare information of the patient named above to:

Name: _____

Address _____

City: _____ **State:** _____ **Zip** _____

Phone Number: _____

Fax Number: _____

I am requesting this information for the following purpose:

- ○ At my request
- ○ Other: _____

This request and authorization applies to:

- ○ My Entire healthcare record
- ○ Other (specify information and treatment dates): _____

If drug/alcohol abuse, psychiatric/mental health or HIV/AIDS related information is to be included, you must check each box below

- ○ **Drug/Alcohol Abuse**
- ○ **Psychiatric/Behavioral Health**
- ○ **HIV/AIDS related information**

Revocation. I understand that I may revoke this Authorization at any time by providing written notice to the address in the header above. I understand that I may not be able to revoke this authorization if MyCatholicDoctor PLLC has taken action in reliance on the Authorization.

Treatment Will Not Be Conditioned on signing of this Authorization. MyCatholicDoctor, PLLC will not condition your treatment based on signing this Authorization

Redisclosure: I understand that once my health information is released pursuant to this Authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Acknowledgement: I understand that signing this Authorization is voluntary, and that I can refuse to sign this Authorization. I acknowledge that I have carefully reviewed this Authorization and understand its provisions.

Expiration. This Authorization shall expire ninety (()) days from the date below.

Patient Name [Pirnted]: _____

Name of Legal Representative [Printed]: _____

Relationship fo Patient: _____

Signature of patient/Legal Representative: _____

Date: _____