The Family Practice & Orthopedic Care Center, PC
Release for Consent of Shared Medical Information

Patient Name: _____ Date of Birth _____

If other than patient, name of person authorizing release: _____
(*legally authorized representative*)

Relationship to patient of person providing authorization _____

I hereby give permission for The Family Practice & Orthopedic Care Center, PC and its employees to provide medical information pertaining to the above named patient as requested by:

_____
Please list all person(s) you wish to have access to the patient's medical information

To further clarify, the above named person(s) may receive the medical information either by phone, fax, or in person. I understand this medical information may contain diagnoses, prognoses, treatment, and/or education related to drug and/or alcohol abuse; communicable and/or sexually transmitted diseases, including acquired immunodeficiency syndrome (AIDS) and results of tests for human immunodeficiency virus (HIV) or HTLV-III antibody, antigen, or nonantigenic products; psychiatric and other mental health services, diagnoses, prognoses, and/or treatment whether rendered prior to this authorization of hereafter; and genetic information and tests results.

Exceptions to this disclosure: _____
_____
_____
Please list Information you wish NOT be disclosed

_____ Date: _____
Signature of Patient/Legal Representative

_____
Relationship of Legal Representative

_____ Date: _____
Staff Member Witness

This authorization shall remain valid from the signed date until such time as written revocation from the patient or patient representative is received in this office.