AGAPÉ PRIMARY CARE

Authorization for Release of Information

Patient Name: _____

DOB: _____

SSN: _____

E-Mail Address: _____

Agapé Primary Care, Inc., is authorized to release protected health information concerning the above named patient to the entities/persons noted below. The purpose is to inform the patient or designee of health matters, as per the patient instructions.

Entity to receive information: Check each person/entity that you approve to receive information:	**Description of information to be released:** Check each item that can be given to person or entity on left in the same section
o Voice Mail-Home _____ o Voice mail - Cell _____ o Voice mail - Ofc _____	o Results of lab test/X-rays o Change in medication o Other _____
o Spouse (provide name) _____ o Parent/guardian (provide name) _____	o Family billing information o Financial matters o Medical information as follows: _____
o Information to employer o Information to school official	o Appointment information o Absent information o Other: _____

Rights of Patient: I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the Notice of Privacy Practices previously provided me, by sending written notification to Privacy officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this information may be subject to re-disclosure by the recipient and may longer be protected by federal state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature: _____ Date: _____
Signature of Patient or Legally Qualified Representative

_____
Relationship of Legally Qualified Representative