Monarch
FAMILY MEDICINE

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MonarchFamilyMedicine.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

I authorize _____
(Previous Healthcare Provider)

to send/disclose OR to receive information from Monarch Family Medicine, LLC.

Purpose of Communication:
Transfer of care/Ongoing healthcare
Communication between healthcare providers for this patient.

Information to be shared:
Medication and Allergy/Intolerance List
Past Medical History or Problem List, Past Surgical History, all lab results, pathology results and radiology results.
This authorization will expire in one year from the patient signature or sooner if the patient should discontinue membership with Monarch Family Medicine.

You have the right to revoke this authorization, in writing, at any time before it ends. This will not apply to any information previously released.

I Understand that:
• I have been offered a copy of this authorization.
• I am not required to sign this release in order to receive treatment.
• Upon request, I may inspect or obtain a copy of the information I am authorizing to be released, and that a reasonable fee may be charged to cover processing costs of this request.
• Information disclosed under this authorization might be re-disclosed by the recipient and this re- disclosure may no longer be protected by federal or state laws.
• This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results unless I limit the disclosure to exclude the following:

Signature of Patient/Representative: _____

Print Name: _____ Date: _____

If signed by person other than the patient, print name and state relationship and authority to do

so: _____