Marcie Lavigne, MD
Lisa Talamantes, MD
Kevin Boehm, MD
Carl Meredith, MD

Coal Creek Family Medicine

Debbie Neeland, PA-C
Katrina Rosin, PA-C
Julie King, PA-C
Jordan Safty, PA-C

Authorization for Release of Protected Health Information

Patient Name (Please Print): ______________________________DOB (MM/DD/YEAR): __________________

If Minor, Parent or Legal Guardian Name: ____________________________Relation: ___________________

Address: _____________________________ City/State: ________________________Zip: _______________

Preferred Phone #: ___________________________ Email Address: _________________________________

Information Authorized for Release:

Dates of Service (Month/Year) From: ____________ TO: _______________

_____ Complete Record
_____ Clinic Progress Notes
_____ Lab Results
_____ Immunization Record
_____ Growth Charts
_____ PAP/HPV Results
_____ Mammography Reports
_____ Bone Density Scans
_____ Mental Health Records
_____ Medication List
_____ Cardiology Studies
_____ Other ______________________
_____ Colonoscopy Reports
_____ ADD/ADHD Assessment

Purpose of Release

_____ Permanent Transfer
_____ Referral to a Specialist
_____ Continuation of Care
_____ Disability Determination
_____ Legal Investigation
_____ Personal Copy ($25 processing fee)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records release:

I understand that if my medical or billing records contains information regarding drug or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and or any other sensitive information, I agree to its release. **Circle One: YES or NO**

I understand that if my medical or billing records contains information regarding HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome testing and/or treatment I agree to its release. **Circle One: YES or NO**

Requesting From:

Name of Practice/Facility/Provider:

____

Address: _______________________________

____

Phone Number: __________________________

Fax Number: ____________________________

E-mail: ________________________________

Releasing To:

Name of Practice/Facility/Provider:

____

Address: _______________________________

____

Phone Number: __________________________

Fax Number: ____________________________

E-mail: ________________________________

Right to Revoke Authorization:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing to the provider authorized to release the protected health information to the address listed below. If I choose to revoke this authorization, I understand that it may not have any effect on any actions taken before the revocation was received by the provider of the information. I also understand that if the requester or the receiver of my protected health information is not a health plan or covered health care provider the released information may no longer be protected by federal privacy regulations and maybe re-disclosed. I hereby release the health care provider from any liability, which may result from furnishing the information requested as authorization in this release. The health provider cannot be responsible for misuse of this information disclosure pursuant to this release.

Patient Signature: ____**Date:** __________________

(This Authorization will automatically expire one year from the date signed.)

If signed by patient representative:

Name: ____**Relationship:** ____________

One patient per form only

If you are requesting records from CCFM, please allow up to 10 business days for processing