P3 Health Partners
People. Passion. Purpose.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Receive Information P3 Health Partners		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

I authorize the release of my entire medical record with the exception of the following (initialed):

( ) Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis

( ) HIV-Related Treatment

( ) Mental Health Information or Psychological Conditions

( ) Alcohol or Substance Abuse Treatment

( ) Genetic Testing

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below.

Signature of Patient or Personal Representative	Date Signed:	Description of Personal Representative's Authority: