Consent Form for Release of Confidential Records/Information

I, _____

Authorize _____
Name and Address of Individual or Organization requested to disclosure records

to disclose the following records regarding _____
Name of Patient

Whose birth date is _____/_____/_____ and whose social security number is _____-_____-_____

To: Koch Family Medicine
411 Maxine Dr
Morton, IL 61550

Records to Be Disclosed

For a complete release of records, initial Part 1. For a partial release of records, initial part 2 and note the exceptions.

Part 1 _____All Medical Records including mental health and developmental disabilities, alcohol and drug abuse and HIV Testing.
Part 2_____All Medical Records including without limitation records concerning any mental health and developmental disabilities, alcohol and drug abuse records and HIV testing, except the following:
_____
_____

Purpose of Disclosure

_____ Transfer of Care _____ Legal Consultation _____ Case Coordination

_____ Consultation w/ Physician _____ Ins. Qualification _____ Treatment Planning

_____ Other: _____

I understand that my records are protected under law and cannot be disclosed without my written permission unless otherwise provided by statutes or regulations. I also understand that I may in writing revoke this consent at any time except to the extent disclosure was made before I revoked it. I further understand that the holder of the record has up to 60 days to comply with the request.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Authorized Person Date

_____ _____
Please Print Name Date