

Green Oaks Medical Center, PC  
Dr. Christine Green

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Authorization for Disclosure or to Obtain Health Information

1. Please check one of the following:

A.  I hereby authorize the office of Dr. Green to **obtain** the following information from health records of:

B.  I hereby authorize the office of Dr. Green to **disclose** the following information from health records of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. This information will be disclosed or obtained from or to:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

Covering the Dates: \_\_\_\_\_ to \_\_\_\_\_

3. Information to be disclosed:

complete health record(s)  discharge summary  
 history & physical examination  progress notes  
 consultation reports  laboratory tests  
 X-ray Reports  photographs/videotapes/digital/other images  
 other (please specify) \_\_\_\_\_

I understand that this will include information relating to (check if applicable):

Acquired Immunodeficiency Syndrome (AIDS)  
 Human Immunodeficiency Syndrome (HIV)  
 behavioral health service/psychiatric care  
 treatment for alcohol and/or drug abuse

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_

5. Green Oaks Medical Center, PC, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein signed:

Patient/or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_