I hereby authorize: Tri-County Family Practice
5551 Wingham Blvd, Suite 142
O’Fallon, Missouri 63368

To Release To____________________________            To Obtain From:_________________________

Fax:___________________________            Phone:___________________________

Fax:______________________________

I specifically authorize the use and disclosure of the following:

☐ Complete medical record(s)          ☐ Discharge Summary          ☐ Progress Notes
☐ History & Physical Examination      ☐ Laboratory Results          ☐ Radiology Reports
☐ Photographs, videotapes, digital or other images    ☐ Other (please specify):__________________

The information to be used or disclosed pursuant to this authorization may include information relating to:
(1) AIDS or HIV infection; (2) treatment of drug or alcohol use; or (3) mental or behavioral health or psychiatric care.

Please DO NOT RELEASE any information, that has been checked below, if it appears in the record.

☐ Alcohol Abuse                  ☐ Drug Abuse
☐ Psychological / Psychiatric conditions    ☐ AIDS / HIV results

I may revoke this authorization in writing at any time. I understand that such revocation will not have any effect on the information already used or disclosed before receipt of my written notice of revocation. Unless earlier revoked, this authorization will expire one year from the date it was signed. I understand I may choose to restrict or extend the expiration date.

I may request to inspect or copy the information to be disclosed. I may refuse to sign this authorization. I understand that I am not required to sign the authorization to receive treatment. Once release of this information is made to the above named person/organization, my information may be subject to re-disclosure by the recipient.

I have read the above information and authorize disclosure of the identified information to the person/organization and for the purpose described herein. I understand that, by signing this document, I release and discharge the disclosing entity from any liability and will hold it harmless for any release made pursuant to the authorization.

Signature:__________________________ Date:__________ Time:__________________________

Relationship to patient:__________________________ Authorization Expires__________________________