CLINE FAMILY PRACTICE
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____ DOB _____ Phone# _____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone # _____ Fax# _____

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone # _____ Fax# _____

I AUTHORIZE the following information to be disclosed: (please initial all that apply)

_____ Entire Record _____ HIV Record _____ Billing Records

_____ Immunization Records _____ STD Record _____ Other

_____ Lab Test _____ Psychiatric/Mental Health

_____ TB Test _____ Alcohol/Substance Use

REASON for disclosure of health information: (please initial)

_____ At my request _____ Job _____ Other

_____ Continuing _____ School

_____ Legal _____ Insurance

EXPIRATION of this Authorization: (please initial)

_____ 90 days after signature date _____ On this date _____

_____ When this event happens: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below +
- I understand that I do not have to sign this authorization to get treatment.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____Date:_____
Client Signature (Parent or Legal Representative, If applicable) Relationship/Authority

+I wish to withdraw this authorization: _____Date:_____