ENGLEWOOD HEALTH
PHYSICIAN NETWORK

PATIENT INFORMATION:
Patient Name:_____

Address (number and street) _____

City, State, Zip Code_____

Telephone_____Date of Birth _____

I hereby authorize and request Englewood Health Physician Network to:

☐ Release information to ☐ Obtain information from

Name/Facility: _____

Address: _____

City, State, Zip Code:_____

FOR THE PURPOSE OF: _____

INFORMATION TO BE RELEASED/OBTAINED

Please specify visit date(s):

_____

_____

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

_____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection

_____Psychiatric Care _____Genetic Information

_____Treatment for alcohol and/or drug abuse _____Sexually Transmitted Disease(s)

_____Tuberculosis

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expire on_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. I understand that I will be given a copy of this form after I sign it.

_____ _____

Signature of Patient or Legal Representative Date

_____

If signed by Legal Representative, Relationship to Patient