

Southdale Internal Medicine, PA  
**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
Print patient's full name

\_\_\_\_\_  
Birth Date (Mo/Day/Yr)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone (home)

I \_\_\_\_\_, do hereby authorize \_\_\_\_\_ (PROVIDER) to disclose my health information as described below: My medical information will be disclosed by PROVIDER's employees and contracted employees under supervision of PROVIDER.

Entire medical record.  
 All records pertaining to selected dates \_\_\_\_\_.

Office notes only.  
 Radiology reports only.  
 Laboratory reports only.

**INFORMATION RELEASE TO:**

\_\_\_\_\_  
Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**PURPOSE OF DISCLOSURE:**

Referral to physician.       Insurance       Personal  
 Legal investigation.       Disability Determination       Continuing Care  
Other (specify) \_\_\_\_\_

I hereby authorize release of my health information under the conditions indicated above. I understand that (i) the information disclosed to a third party in accordance with the terms of this authorization may be re-disclosed, and (ii) once disclosed to a third party, my health information may no longer be protected by federal privacy regulations. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Southdale Internal Medicine. I understand that I may revoke this authorization at any time by notifying the Southdale Internal Medicine, P.A. Privacy Officer in writing.

This authorization expires on \_\_\_\_\_  
(Date)

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient's representative

\_\_\_\_\_  
Relation to patient or authority to act