DRAVES FAMIY PRACTICE
1471 US HWY 61
FESTUS, MO 63028
(636) 937-2700

Notice: We are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment or health care operations. Specific information about how we can use or disclose your health information can be reviewed in our Notice of Privacy Practices.

Name of Patient : _____ **Date of Birth:** _____

I hereby authorize Draves Family Practice to: _____ **disclose/release to** _____**obtain from**

_____
Name of Physician, Practice or Hospital

_____
Address:

I authorize the following health information be released:
_____Entire Medical Record

_____Immunization Record

_____Draves Family Practice office notes from _____ to _____

_____Laboratory results from _____to_____

_____x-ray and/or imaging results from _____to _____

_____ Other (must specify) _____

For the purpose of :

_____Transfer of treatment to another agency, facility or physician
_____Consultation with another physician
_____Other (must specify)_____

I understand that this authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection, psychiatric care, behavioral or mental health services, treatment for alcohol and/or drug abuse and genetic testing.

I understand that this information disclosure may be subject to re-disclosure by the recipient and no longer be protected by Draves Family Practice. Draves Family Practice and its staff are hereby released from any legal responsibility or liability for disclosure of the above information. I also understand that I have the right to read and/or obtain copies of the information to be disclosed.

I understand that I have the right to revoke this consent by written statement at any time; otherwise, it will automatically expire 60 days from the date of authorization which is _____/_____/_____.

I understand that refusing to sign this form will result in records not being released

Signature of Patient, Parent or Legal Guardian _____

Printed name of Patient, Parent or Legal Guardian _____

Date _____ Relationship _____