www.medicalhousecalls.com
57190 Main Rd, Southold, NY 11971
info@medicalhousecalls.com

Medical: 631-626-1006
Physical Therapy: 631-765-3620
Fax: 631-477-6219

PATIENT MEDICAL INFORMATION RELEASE

Patient Name:____________________________ DOB:_____________________

Address:____

Medical House Calls of the North Fork is authorized to

( ) **Furnish** ( ) **Receive** (check which applies)

Medical records to/from any Hospital, Facility, or Doctor

OR Specific Recipient/ Discloser:

____

____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS

( ) I GIVE PERMISSION TO THE RELEASE OF MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/ dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any

( ) I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below.

____

____

I release Medical House Calls of the North Fork and the Recipient/ Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Medical House Calls of the North Fork, provided that I do so in writing and to the extent that you already disclosed the information in reliance on this authorization.

This authorization expires ___/___/_____(optional) *if no expiration date is given, then this authorization shall remain in effect for 12 months from date of signature.*

____ ____________________

Patient Signature (Legal Representative) *Date*