CARITAS

FAMILY MEDICINE

Dr. Jeffrey A. Cannon Dr. Michael J. Rosedale

PERMISSION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____

I hereby authorize my health care information be released to the following recipients:

Name: _____ Relation:_____

Address: _____ Phone: _____

Name: _____ Relation:_____

Address: _____ Phone: _____

Name: _____ Relation:_____

Address: _____ Phone: _____

This authorization is for sharing of:

- ❑ ALL RECORDS
- ❑ All records EXCEPT:
  - ❑ Office notes
  - ❑ Hospital notes
  - ❑ EKG
  - ❑ Xray reports
  - ❑ Immunization records
  - ❑ Lab reports
  - ❑ General correspondence
  - ❑ Consultation reports
  - ❑ Billing records
  - ❑ Substance Abuse Record
  - ❑ Results of HIV testing
  - ❑ Mental Health Treatment Records
  - ❑ Other: _____

Patient/Custodian Signature: _____ Date: _____

This authorization will remain in effect until the patient notifies Caritas Family Medicine in writing to cancel this authorization.

Bring to office, or form may be faxed to 210-650-9067 or emailed to caritasefaxdocument@gmail.com.