Release of Information

Patient Name			**Date**
ID#	**DOB**	**AKA's**	

I Authorize	To Release Information To
Name of organization or individual:	Facility:
Address:	Address:
Phone #	Phone #
Fax #	Fax #

I hereby give my consent for the above-named facility to release the following information from my medical records to CFG Health from Dates _____ to _____.

☐ Provider's summary of my diagnosis, medications, treatments, prognosis and recent care.

☐ Admission Reports	☐ Discharge Reports	☐ Operative Summary Reports
☐ Immunization History	☐ Radiology Reports/Studies	☐ Laboratory Reports
☐ Drug and or Alcohol Treatment & History	☐ Mental Health Records	☐ ALL MEDICAL RECORDS
☐ Other Records: _____		

I understand that this authorization is voluntary, and that I have the right to revoke this authorization at any time by providing written notification. I also understand that once this information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and no longer protected by federal privacy regulations.

CFG Health and the above-named facility accepts no liability for confidential information moved from the network to other media or persons, such as by copier, printers, email, fax machines, home, or laptop computers. The content is confidential and intended solely for the use of the individual or entity to which they are addressed. If you are not the intended recipient you are notified that disclosing, copying, distributing, or taking any action in reliance on the contents of this information is strictly prohibited.

I understand this authorization shall remain in full force and effect for the period of _____ from today's date unless withdrawn in writing by me.

I sign this willingly and I release CFG Health and the facility from any liability which may result from such release of information.

I understand that my refusal to sign this form will not affect my ability to receive treatment.

Patient Name	**Patient Signature**	**Date**
Health Staff Name	**Health Staff Signature/Title**	**Date**

Facility/Provider to Receive Information

This information has been disclosed to you from records whose confidentiality is protected by State law. State regulations prohibit you from making any further disclosure of this information without the prior written consent of the person to whom it pertains.