

Mt. Vernon Primary Care Associates
HIPAA RELEASE

Patient Name (Please Print): _____ **Patient DOB:** ____/____/____

I give permission for the following person(s) to have access to the information listed below:

Name of Person(s) & Relationship:	Contact phone #:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please check all that apply:

- _____ Referrals
- _____ Prescriptions
- _____ Discuss Medical Info
- _____ Copy of Medical Record *(must also sign medical record release form)*

I hereby authorize disclosure of my health information to the above named person/persons. I understand that I may cancel this request with written notification but that will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider whom this authorization is furnished may not condition his/her treatment of me on whether or not I sign the authorization.

**Signature of patient or guardian or
Personal Representative of patient's estate**

Date