SUMMIT VIEW CLINIC INC., P.S.
FAMILY PHYSICIANS

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

PREVIOUS NAME(S) _____ SOCIAL SECURITY NUMBER _____

We have a legal obligation to keep your personal health care information confidential. For convenience, some patients wish to allow relatives or other individuals access to test results or other orally transmitted health care information. If this is your desire, please list below the name and relationship to you of those individuals in the spaces provided. Copies of your chart or other written information are not covered by this authorization. This authorization will remain in effect until revoked in writing.

SVC may use or disclose health care informaiton regarding testing, diagnosis, and treatment for everything EXCEPT (check to EXCLUDE):

☐ HIV/AIDS ☐ Sexually Transmitted Diseases ☐ Mental Health Issues ☐ Drug/Alcohol Use

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

PATIENT/PARENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE _____ DATE AND TIME _____

PRINTED NAME _____ RELATIONSHIP _____

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