



Authorization for Release of Information

Patient Name: _____
 DOB: _____
 SSN: _____

Agapé Physicians Care, Inc., is authorized to release protected health information concerning the above named patient to the entities/persons noted below. The purpose is to inform the patient or designee of health matters, as per the patient instructions.

Entity to receive information: Check each person/entity that you approve to receive information:	Description of information to be released: Check each item that can be given to person or entity on left in the same section
<input type="radio"/> Voicemail - Home _____ <input type="radio"/> Voicemail - Cell _____ <input type="radio"/> Voicemail - Office _____	<input type="radio"/> Results of lab test/X-rays <input type="radio"/> Change in medication <input type="radio"/> Other _____
<input type="radio"/> Spouse (provide name) _____ <input type="radio"/> Parent/guardian (provide name) _____	<input type="radio"/> Family billing information <input type="radio"/> Financial matters <input type="radio"/> Medical information as follows: _____
<input type="radio"/> Information to employer <input type="radio"/> Information to school official	<input type="radio"/> Appointment information <input type="radio"/> Absent information <input type="radio"/> Other: _____

Rights of Patient: I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the Notice of Privacy Practices previously provided me, by sending written notification of Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this information may be subject to re-disclosure by the recipient and may no longer be protected by federal state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature: _____
Signature of Patient or Legally Qualified Representative

Date: _____

Relationship of Legally Qualified Representative