Ideal Family Healthcare, P.C.

Patient Request for Release of Protected Health Information

By my signature below, I request that the following Facility or Individual:

______________________________ ______________________________

Facility or Individual Name Address

______________________________ ______________________________

Facility or Individual Phone City

______________________________ ______________________________

Fax State Zip Code

…to release certain protected health information (PHI) about me to Dr. Sharp at:

Ideal Family Healthcare, PC
335 Manitou Avenue
Manitou Springs, CO 80829

Fax (719) 686-7449
Phone (719) 686-8844

I understand this authorization permits the facility or individual specified above to diagnose my medical/psychiatric condition, plan my care and treatment, communicate the information to other health professionals, document services for payment/reimbursement and otherwise use and/or disclose the following individually identifiable health information about me

- ☐ Office visit notes
- ☐ Laboratory results
- ☐ Surgery or procedure notes
- ☐ Radiology reports
- ☐ Vaccination Records
- ☐ Other ____________________

Please release the following sensitive PHI regarding testing, diagnosis or treatment of:

- ☐ *Drug and/or alcohol abuse*
- ☐ *Psychiatric disorders/mental health*
- ☐ *HIV/AIDS*
- ☐ *STDs*

The information will be used for ongoing medical care at Ideal Family Healthcare, PC.

Signed by: ______________________________ ______________________________

Print Patient's Name Date of Birth

______________________________ ______________________________

Phone Number Social Security Number

______________________________ __________ ______________________________

Signature of Patient or Legal Guardian Date Expiration Date for Records

______________________________ ______________________________

Print Name of Legal Guardian *Relationship to patient*