MEDICAL RECORDS RELEASE AUTHORIZATION

U.P. North Family Medicine DPC, PLLC

I hereby authorize_____(medical facility) to release my individually identifiable health information as outlined below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory and imaging reports, medical history, treatment, and any other such related information. I understand that this authorization is voluntary, and I may refuse to sign it. I further understand that for me to receive the best health care that this authorization is highly encouraged.

_____ _____ _____

Patient name (please print) Date of birth Phone number

_____

Address (including City, ST, and zip code)

Information to be released:

☐ Complete records from last 3 years including lab and imaging reports, preventative measures (colonoscopies, mammograms, etc.), and correspondence, and/or:

☐ Other _____

Purpose of releasing records:

☐ Transfer of care

☐ Other _____

Please release the above information to Kelly Freberg-Ash, MD (kelly@upnorthfamilymedicine.com) or via fax at 906-263-3682, Or via U.S. Mail to U.P. North Family Medicine DPC, PLLC (address below)

_____ _____

Signature Date