MEDICAL RECORDS RELEASE AUTHORIZATION - OUTGOING

U.P. North Family Medicine DPC, PLLC

I hereby authorize U.P. North Family Medicine DPC, PLLC 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 to the medical facility listed below. 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. I further acknowledge that the validity of the recipient will be verified by U.P. North Family Medicine DPC, PLLC in a time-dependent (emergency) manner. This agreement with the most recent date will supersede any prior signed agreements.

Patient name (please print) _____ Date of birth _____ Phone number _____

Address (including City, ST, and zip code) _____

Location:

☐ **SMH Emergency Department (ER)**

☐ **Any other Hospital ER upon emergency request**

Signature _____ Date _____