

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Complete this form if you want a copy of your medical records transferred to this practice from another physician

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____
(name, address and phone number of former physician or practice)
to release healthcare information of the patient named above to:

TWIN FORKS FAMILY PRACTICE, LLC

Donna M. Prill, MD

Kristen J. Casillo, RPA-C

34 East Montauk Highway, Suite 4
Hampton Bays, New York 11946
631-728-0505
631-728-4038 (FAX)

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

If Applicable:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

