Informed Consent Medical Records Release

Garcia Plastic & Hand Surgery
Juan C. Garcia, MD, FACS, PLLC
15 E Washington Street, Glens Falls, NY- 12801
Phone: 518-793-0475 Fax 518-793-6658

This form must be signed by the patient or person authorized by law.

Name: _____

Address: _____

Date of Birth: _____

Other names (if applicable): _____

I, _____, permit Garcia Plastic & Hand Surgery/Juan C. Garcia MD, FACS, PLLC to release my protected health information to:

Name of Entity: _____

Description of information to be disclosed: _____

_____

Fax Number: _____

Reason for requested use or disclosure:_____

I understand the following:
I may revoke this authorization at any time by providing written notice to the practice.
I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or the authorization was obtained as a condition of obtaining insurance coverage.
I am signing this authorization freely.
No one has pressured me to sign this authorization.
The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use of this authorization.

This authorization will not be valid one year from the date below.
My signature confirms that I have read, understood, and authorized the release of information described above.

Patient Signature: _____ Date/Time_____
(Signature of Patient's Representative)
Patient Representative's Name: _____

Relationship to Patient: _____