Eagle Physicians & Associates, P.A.

Authorization to Disclose Protected Health or Billing Information Request

I give my permission to release the health information of:

Patient Name _____ DOB _____

Street Address _____

City, State, Zip _____ Phone _____

Release Information:

FROM	TO
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____
Fax _____	Fax _____

Purpose of Release (check reason): ☐ Request of individual/personal ☐ Insurance ☐ Disability ☐ Transfer ☐ Legal ☐ Continuation of Care ☐ Other: _____

Please Send:

☐ All (including Visits/Xrays/Labs/Imaging)

("All" records = last 3 yrs of records unless otherwise indicated here _____)

☐ Specific Dates(s) of Service _____ to _____

☐ Office Notes ☐ Specific Xrays/Imaging _____

☐ Specific Labs _____ ☐ Other _____

☐ Other _____

I understand that I am authorizing the release of all medical information from my chart unless specifically restricted as indicated below:

☐ HIV/AIDS or related testing ☐ Mental Health ☐ Chemical Dependency (drug/alcohol)

This authorization is valid for 180 days from the date signed or until _____ whichever is shorter. This authorization may be revoked at any time by notifying your physician's site in writing, except when this authorization was obtained as a condition of acquiring life insurance coverage. Eagle Physicians & Associates and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected.

_____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient, if not Patient

AR # _____

NOTICE: There may be a charge for this service.