



# 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.**