Powers HEALTH℠

Authorization for Quick Release of Patient Identifiable Health Information by Powers Health Medical Group

Patient Name		Phone Number	
Address		Date of Birth	
City, State, Zip Code		Social Security Number (last 4 digits only)	

I authorize: _____

(Specify PHMG Provider)

This information is to be released to the following individual: _____

(Please Print)

The information I authorize disclosed is: Date(s) of Service _____

- ❑ Test Results
- ❑ Reports
- ❑ Provider Notes
- ❑ Immunizations
- ❑ After Visit Summary (AVS)

I understand:

- My health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- The person picking up my records must be able to provide their identity with a valid driver's license or state identification card.

_____ _____ _____

Signature of Patient *Date* *Time*