

Faña Medical Group

CONSENT FOR RELEASE of CONFIDENTIAL MEDICAL INFORMATION

I _____ hereby authorize Faña Medical Group to release my healthcare information to:

1. _____
Print name of party authorized to receive information Relationship to patient

_____ _____
Address of party listed above Telephone number of party listed above
2. _____
Print name of party authorized to receive information Relationship to patient

_____ _____
Address of party listed above Telephone number of party listed above
3. _____
Print name of party authorized to receive information Relationship to patient

_____ _____
Address of party listed above Telephone number of party listed above

I authorize the release of my entire medical record via either telephonic, face-to-face, or written communication to the above named individual(s). Unless otherwise indicated, my authorization includes the release of the following, please strike those you wish to **exclude**, if any:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment.
- Genetic test results and/or related treatment.
- Other: _____

[] By checking this box, I agree to allow messages containing personal health information on my answering machine. If this box is not checked, only brief, non-specific messages may be left.

I further release and indemnify Faña Medical Group, its affiliates, employees, officers and directors from any and all liability, which in any way results from the disclosure of the information pursuant to the above Instruction. This authorization shall remain in effect from the date signed until written revocation is received. I understand that I am under no obligation to sign this release of information and that it is my right to inspect all information disclosed, if I so request.

Signature of Patient

ID or SS#

Date of Birth

Date