SEBREE
MEDICAL GROUP

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Sebree Medical Group, LLC to:
Patient/Legal Representative

☐ Allow Reviewed Records
☐ Release Copies of Protected Health Information for:
☐ Obtain Records

_____ _____
Patient Name Date of Birth

From:
Name of individual, healthcare facility or agency: _____
Address of individual, healthcare facility or agency: _____
Phone: _____ Fax: _____

Send Records to: **Sebree Medical Group, LLC Fax: 270-318-3131**

For the purpose of:
☐ Continued Treatment ☐ Personal Use ☐ Patient Communication
☐ Other (Please specify) _____

Date(s) of Service: From _____ To _____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental Health, alcohol, drug, IV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected by this rule. I further understand that Sebree Medical Group, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

_____ Complete Record
_____ Abstract Record

_____ All Diagnostic Test Results
_____ Therapy Records
_____ Consultation/Progress Notes
_____ Radiology only
_____ Pathology/Operative Report(s)
_____ Lab only
_____ Other (Please specify) _____

In addition, place your initials by each specific item: (If applicable)

_____ Mental Health
_____ Drug and/or Alcohol
_____ HIV Testing
_____ Genetic Counseling/Testing Information
_____ AIDS Information

Patient Name: _____

Patient Date of Birth: _____

_____ _____
Parent/Legal Guardian Signature or Patient/Legal Representative Date of Authorization