OFFICE VISIT

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

AFC STAFF COMPLETES		
	Patient Name:	
	Patient DOB:	Patient SSN:
	Purpose of Release: At the request of patient.	
	I hereby authorize American Family Care, Inc. and its affiliates[1] and/or Occupational Health Services of America, Inc. to release the following: Any medical records and/or medical information.	
	Name of Individual Requesting Release:	Relationship to Patient: ☐ Self ☐ Parent/Guardian of minor under age 14 ☐ Legal Counsel – provide copy of legal representation document ☐ Other – specify:
	Authorization Begins (Date of Visit):	Authorization Expires: Authorization expires one year from Begin Date if left blank

TO BE COMPLETED BY PATIENT

Name and address Individual(s) to whom medical records or information may be released:

1._____

2._____

3._____

I understand that, in compliance with Privacy Act regulations (45 CFR 164.508(c)),

- I request and authorize release of the information described above to the party named.
- This release is voluntary and I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the entity named above.
- I may refuse to sign this authorization and such refusal will not affect my treatment.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information.
- I have a right to a copy of this signed authorization.

Patient's Signature:	Date of signature:

[1] AFC Physicians of Florida, PA, American Family Care Florida, LLC, AFC Physicians of Tennessee, PC, American Family Care Tennessee, LLC, AFC Physicians of Georgia, PC, American Family Care Georgia, LLC, AFC Physicians of Georgia Primary Care, PC