

Authorization to Disclose Protected Health Information to:

Longneck Family Practice, P.A.
32060 Long Neck Rd.
Millsboro, DE 19966
www.longneckfp.com
(302) 947-9767 Fax: (302) 947-9558

By signing, I herby authorize:

Name: _____
(Name of physician/school/agency)

Address: _____ City: _____ State: _____ Zip Code: _____

To release the following information to Longneck Family Practice, P.A.:

Name of Patient: _____

Date Of Birth: _____ Gender M F SS# _____

Home Address: _____

Mothers Name: _____ Fathers Name _____
(In case of minor)

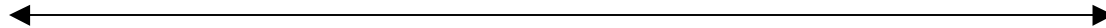
INFORMATION REQUESTED:

1. Dates of Treatment From _____ To _____

2. Check information that may be released.

- Office Notes Laboratory Reports Hospital Reports Consulting Reports
- X-ray Reports Ancillary Service's Reports Therapy's
- HIV/AIDS Results Drug/Alcohol Results Psychiatric/Psychology Notes
- Other _____

Longneck Family Practice P.A. will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the Protected Health Information.



I would like this authorization to expire on/or after the date/event listed: _____

I understand this authorization is only valid for **60 days** from the date of signature if I do not specify a date. I understand that I may revoke this consent at any time but not retroactive to the release of information made in good faith. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule. I understand that treatment, payment or other benefits cannot be conditioned on the execution of the Authorization.

Date

Signature of Patient/Legal Representative