**Anthony C. Zwaan, MD**
*Family Medicine*
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# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

Patient's Name:________________________________________Date of Birth:________________

I request and authorize **Dr. Anthony Zwaan** to release protected health information/medical records of the patient named above to:

Name:____________________________________________________________

Address:__________________________________________________________

City:____________________________________State:_________Zip Code:_______

Phone:_______________Fax:__________________email:______________________

**HIGHLY CONFIDENTIAL INFORMATION:**
*The person listed above is hereby notified that the patient must give specific written permission before disclosure of this information to anyone else.*

I authorize the release of information regarding sexually transmitted diseases, including HIV/AIDS testing, whether negative or positive, to the person listed above.

☐ Yes* ☐ No

I authorize the release of information regarding any diagnosis or treatment of mental health conditions.

☐ Yes* ☐ No

I authorize the release of information regarding drug or alcohol use.

☐ Yes* ☐ No

*(*Recommended; If you do not select these, release of information may be substantially limited.)*

**This request and authorization applies to:**

☐: Health care information and records generated while under Dr. Zwaan's care. (Recommended) **

☐: All health care information and records. (General and Complete Release) **

☐: Health care information relating to the following treatment, condition or dates. (Limited Release)

__________________________________________________________________

☐: Other:________________________________________________________________

**Please note that for record transfer, a copy fee of $15.00 or $0.50 per page, whichever is greater, is due upon request/receipt.

♦ I understand this authorization may be revoked in writing at any time unless that information has already been disclosed prior to the date of revocation.
♦ I also understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may no longer protect it.

Signature:_____________________________________________Date Signed:____________________
(Patient, Parent or Guardian) (Expires 6 month/180 days from this date)