Sojourns
COMMUNITY HEALTH CLINIC

Consent for Release of Confidential Information

Name:

Former Names (if applicable):

Address:

City | State | Zip Code

Date of Birth:

I REQUEST AND AUTHORIZE

Name:

Address:

City | State | Zip Code

Phone Number: Fax:

TO DISCLOSE THE FOLLOWING INFORMATION:

- ☐ Lab work and results
- ☐ X-rays and results
- ☐ Other, please specify:

For the following dates:

To be released and forwarded to:

Address:

City | State | Zip Code

Phone Number: Fax:

THE REASON FOR THE RECORDS RELEASE IS:

- ☐ Coordination of care
- ☐ Transferring of Primary Care
- ☐ Other, please specify:

- I understand that this authorization will extend to all aspects of health care received, including but not limited to, diagnosis and/or treatment for sexually transmitted diseases and substance abuse.
- I understand that my medical records are protected under federal and state confidentiality laws and cannot be disclosed with out my written consent unless otherwise provided for by law.

NOTE: RECORDS OVER TEN PAGES WILL NEED TO BE MAILED.

By typing my name into this box, I hereby agree that this action constitutes my electronic signature.

Patient Signature: Date