AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION

Our patient/physician with you is held in strictest confidence. We will not discuss **anything** about your medical condition or care plan with anyone including parents, spouse or child without your written permission to do so.

☐ I request that Adult Medicine Specialists **NOT** discuss my private health information and care plan with anyone.

If you want to avail other people to your private health information please fill out the bottom of this form to authorizing us to release your private health information to the people named below.

☐ I ___________________________________authorize Soni Family Practice, PLLC to release my private health information to the following people.

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

By signing my name below I am being made aware that your private health information may be communicated in person, by telephone, fax, US mail or e-mail. Sexually Transmitted Diseases and HIV, drug/alcohol abuse can only be delivered to the patient in person and will be reported to the Polk County Health Department

Patient Signature ______________________________ Date ____________________

Witnessed by; Name ______________________________ Witness Signature ______________________________

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