Release Medical Information to Others

I _____ *(Patient or Guardian)* hereby authorize DrYoungForever (DYF), YoungForever MedSpa and/or Robert N. Young, MD to release and disclose information from the medical record of:

Name _____ Date of Birth _____

Social Security # _____

Please release the following information :

☐ Entire Medical Record	☐ Progress Notes	☐ Laboratory Results	☐ Diagnostic Work
☐ History / Physical Exam	☐ Medication List	☐ EKG	☐ List of Allergies
☐ Insurance Information	☐ Photos	☐ Non-Surgical Procedures	☐ All Surgeries

☐ Surgeries from _____ to _____

For the Purpose of _____

Release the information to:

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the organization or individual releasing the information on behalf of the facility. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify, this authorization will expire in one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Facility Privacy Officer.

If medication information is being released directly to myself (patient), I understand that it may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold DrYoungForever, YoungForever MedSpa, Dr. Young or my provider, technician, staff or agents of DYF liable for any misinterpretation in my medical record as a result of not consulting my physician for the correct interpretation.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) and Hepatitis B Virus. It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Date Request Completed _____ # Pages Copied _____ ☐ Reviewed Only Fees Paid $_____ Initials _____ Rev 12-01-19 ALA