Congenial Healthcare LLC

Authorization For Use or Disclosure of Medical Record Information

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Patient Address:	=	-		me Phone:			
City:	State	Zip:		ork Phone:			
Release Informati	ion To	-			-	-	
hereby Authorize Conger	nial Healthcare LLC to	o release my me	edical record in	nformation t	o / obtain info	ormation fron	ո:
Name/Facility:			At	tention:	 		
Address:			Pr	one:			
City:							
Purpose of Request:	O Personal O Refe	erral or 2nd Opinion	O Legal	O Insurance	Other_		
	O Transfer from Practi	ice/Reason?					
Information to be	Released						
Please provide a 2 year a *The fee is \$25.00 or MA		s			— Comments	100	
O Please provide a 5 year a	abstract of my records -	-	×				
*The fee is \$50.00 or MA		=					
Other - more than 5 years	s - nieasesnecity in comi						
Other - more than 5 years *The fee is \$ 75.00 or MA							
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^{*}The term *genetic tests means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

*If you are the legally recognized representative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy provides a provide a provide and the provide protection laws. Family Medicine North will not condition treatment on payment of the provision of this Authorization.