Authorization to Use or disclose protected health information.

Patient Name____________________________DOB__________________SSN_________________

Address (street, city, state, zip)____

Please check one of the boxes below for release of medical information:

Release information only to me: ___Yes ___No

- ☐ All Records
- ☐ X-ray reports
- ☐ Physician notes
- ☐ Lab results
- ☐ Radiology scans
- ☐ Other _________________________

Release information to spouse or other person listed: __Yes __ No

Spouse's Name/other: ____

Release records to other: __Yes __No

Name: ___________________________________ Phone #________________________________

Address_____________________________________City/St/Zip_______________________________

If you need to contact me you may leave messages on my answering machine? _Yes _No

Phone #_____________________This Does/Does Not identify me by name? (circle)

Signature _______________________________________ **Date:** ______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

MNG reserves the right to modify the privacy practices outlined in the notice. I understand that the information in my record may include information relating to sexually transmitted diseases, HIV/AIDS, or any other medical condition. It may also include information about behavioral or mental health services or treatment for alcohol and drug use. I also understand my information will be released and shared among healthcare professionals involved in my care and to my insurance plan for processing of claims. I have received a copy of the Notice of Privacy Practices for MNG. 'I understand in order to revoke this authorization I must do so in writing.

___________________________	___________________________
Name of Patient (Print)	Signature of Patient
___________________________	___________________________
Signature of Patient's Representative (Required if the patient is a minor or an adult who is unable to sign this form)	Relationship to Patient
___________________________	___________________________
MNG Signature	Date

Expiration of Release ________________________

SUBMIT FORM