ROBERT L. HOGUE, M.D., F.A.A.F.M.
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AUTHORIZATION FOR RELEASE OF INFORMATION
THIS REQUEST MUST BE FILLED OUT COMPLETLEY

Patient's Name: _____ DOB: _____

Address: _____State: _____ Zip: _____

Phone #: ( ) _____-_____ SS#: _____/_____/_____

I authorize Dr. Robert Hogue to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for Psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. 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 the federal and state privacy regulations. I understand that my health care and the payment of health care will not be affected if I do not sign this form.

***Information to be released TO*:** ***Information to be released FROM*:**

_____ _____

_____ _____

_____ _____

Information to be released: (Check all that apply)

___Medical Records last 3 years ___Operative Reports ___Consultations
___Medical Records last 5 years ___Pathology Reports ___X-ray Reports/Disk
___Laboratory Data ___Immunization Records
___Other (Specify) _____

Reason or Purpose for Release: (Check the appropriate category)

___Continued Patient Care ___Insurance Claim/Application
___Disability Determination/Social Security ___Other specify) _____
___I am transferring my care to another provider for the following reasons: _____
_____

I understand that the information released is for specific purpose stated above. Any other use of this information without written consent of the Patient is prohibited. I further understand that I may revoke this consent (in writing) at anytime except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the date of my signature unless otherwise specified.

_____ _____
***Signature of Patient or Guardian** ***Date**

_____ _____
Relationship to Patient** *** *Witness By***

----------***Office Use Only***----------

Records picked up: _____ *Records/Release Sent:* _____ *Date:* _____ *Initial* _____ *5/20/19 thl*