SOUTHERN FAMILY MEDICINE, LLC
AUTHORIZATION FOR OBTAINING HEALTH INFORMATION

I hereby voluntarily authorize **Southern Family Medicine, LLC** to obtain my protected health information ("PHI") for the purpose of continuing medical care/transfer of care from:

Physician/Practice Name _____
Address: _____
_____
Phone: _____

I. Individual Information

Name: _____
Address: _____
_____
Phone: _____
SSN#: _____

II. Identification of Person or Organization Receiving Information

My protected health information may be disclosed to the following person(s) or organization(s): *(attach more sheets if necessary)*

Southern Family Medicine, LLC
16312 Mt Airy Rd
Shrewsbury, PA 17361
717.227.3800 (main)
717.227.3802 (fax)

III. Purpose(s) for the Release or Disclosure of Information

☐ Disclosures to be made at the request of the individual

☐ Other (*please specify)*:_____

IV. Description of Information to be Released or Disclosed *(check all appropriate)*

☐ Lab Results

☐ X-Rays

☐ Diagnostic Testing Results

☐ Medical Record

☐ Other: *(please specify)*_____

V. Other Important Information

Your signature below means that you understand and agree to the following:

√ The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS), and/or genetic marker information. These records will be included in the information provided to SFM.

√ Your ability to receive health care treatment from SFM will not be affected if you do not sign this form. However, without your signature, your request to release the information described above will not be honored.

√ You may receive a copy of this form if you ask for it by writing to the address listed at the bottom of this page.

√ This authorization will expire one year from the date you sign this authorization. If you sign this form, you may revoke the authorization at any time by notifying SFM in writing at the address below. Revoking this authorization will not have any effect on actions that SFM took in reliance on the authorization before SFM received notice of your revocation.

VI. Signature of Individual or Individual's Representative

_____ _____

Signature of Individual or Representative Date

If this authorization is signed by an individual's representative, the following additional information must be provided:

_____

Name of personal representative (please print)

_____

Relationship to the individual, including authority for status as representative

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16312 Mount Airy Road
Shrewsbury, PA 17361