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HERITAGE VALLEY
Health System

Cherrington Medical Associates
Authorization for Release of Protected Medical Information

I hereby authorize the release of information from the record of:

____
Patient Name (Please PRINT)

______________________: ___/____/____ (as described) to the following individuals.
Social Security # Pt. Birth Date

Name of Person or Facility	Relationship	to Patient
Name of Person or Facility	Relationship	to Patient
Name of Person or Facility	Relationship	to Patient
Name of Person or Facility	Relationship	to Patient
Name of Person or Facility	Relationship	to Patient
Name of Person or Facility	Relationship	to Patient

The information in my Medical Record may be released to the above individuals either by phone or in consultation by any of the providers in the office of < Practice Name>

HIV, Behavioral Health and Drug & Alcohol information contained in the records indicated above will be released through this authorization unless otherwise indicated.
Dot not release: ☐ HIV ☐ Behavioral Health (Psychiatric) ☐ Drug & Alcohol

I understand that this authorization will stay in effect until revoked by me in writing.

General Authorization

______________________________________ ____________________
Patient Signature Date