FLYNN FAMILY MEDICINE

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____
Mailing Address City /State Zip Code

Date of Birth: _____ Social Security Number: _____

Authorizes: Name of Facility/Physician: _____

Address: _____

City,State, Zip Code: _____

Please release the following medical information to:

Drs Adam and Marisa Flynn
Schulstraße 4
66877 Ramstein-Miesenbach
Rheinland-Pfalz, Deutschland
Fax:06371 4078711

☐ Progress Notes ☐ Operative Reports ☐ Lab Reports ☐ X-Ray Report ☐ Pathology Reports

☐ HIV Test Results ☐Other (please specify) _____

___Mail Records ___Fax Records

Purpose of Disclosure: Medical Care

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall ☐**not expire;** or shall expire in ☐**180 days** from the date of my signature, unless specitied in writing here:

(Please choose one of theabove)

_____

Patient's Signature

To The Party Releasing This Information:

I, the undersigned, have read the above and authorize the person orfacility noted above todisclose such information as herein contained. I understand that when this information is used ordisclosed pursuant to this authorization, it may be subject to re- disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility or Physician from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____

Patient's Signature **Witness**

_____ _____

Date Date