



Deer Park Family Doctors

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____

Other names used: _____

Date of Birth: _____ Social Security #: _____

I hereby consent to the release of all medical information related to the treatment of the above named patient from the following (physicians, hospitals, labs, etc.):

Specific Information to be Released:

“Diagnosis, prognosis, plan of treatment and demographic information.”

other: _____

Covering Treatment from _____ to Present

Released to: **Drs. Hammond and Weiss**
Deer Park Family Doctors 1603 Stevens Ave, Louisville, KY 40205
502-451-5955 office 502-451-5925 fax

Released for Stated Purpose ONLY: (Any other use is forbidden)

“Diagnosis and Treatment”

other: _____

**THIS CONSENT WILL CONTINUE IN FORCE AND EFFECT
UNTIL REVOKED BY ME IN WRITING.**

Date: _____ Signed: _____
Patient, or Party Authorized to Consent (please note relationship)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal Regulation (42 CFR Part 2).