United Health Professionals, Inc. 143 Peyton Street
Authorization for Release of Information– JASON HUDAK, MD Barboursville, WV

Patient Name	Last		First	MI	Maiden/Other
DOB Mo	Day	Year	SS#		Med Rec #
Address			City		State/Zip
Day Phone (with area code)			Evening Phone		Cell Phone

CHOOSE ONE

[ ] I authorize UHP to release information ***TO:***

Hudak Family Medicine, PLLC
5990 US Route 60 East
Barboursville, WV 25504
Phone: 304-733-5990
Fax: 304-733-5991

[ ] I request that my records remain with United Health Professionals, Inc. where I will continue to receive my primary care services.

RECORDS

Release the following information:

( ) AT NO CHARGE- Problem list, medication list, first visit with Dr. Hudak, last two visits with Dr. Hudak, labs and imaging studies within the last year.

( ) ADDITIONAL RECORDS AT $0.75 PER PAGE– please specify records needed and date range. ("all records" is not acceptable):

I specifically authorize the release of information related to:

( ) **Substance Abuse** (including alcohol and drug abuse)
( ) **Mental Health** (including psychotherapy notes)
( ) **HIV related information** (AIDS related testing)

Signature of patient/legal guardian/authorized person

PURPOSE

Information is to be released for the following purpose(s):

( ) Continuing Medical Care with Dr. Hudak

NOTE

I understand the following:

- This authorization will expire 60 days after I have signed this form.
- I may revoke this authorization at any time by notifying the providing organization in writing. My notification will be effective on the day it is received expect to the extent action has already been taken on the original request.
- The information used before this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

SIGN HERE

Signature of Patient/Legal Guardian/Authorized Person Date Witness

Records Received by Date Relationship to patient

***Office Use*:** Date Completed: by: ID presented: Fee collected: $