AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

_____

Print Patient Name DOB SS#

_____

Name of Designated Facility or Provider

_____

Address

I request and authorize the facility or provider named above to release health care information to:

Information to be Released

____ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
____ All Medical Records ___ Work Comp - Date of Injury _____
____ All Billing Records ___ MVA – Date of Accident _____
____ Specific Information, to include: _____

Purpose for which Disclosure is being made: (Please Check)

___ Physician ___ Personal ___ Attorney ___ Insurance

Patient Authorization

I understand that this consent may disclose information which may include information concerning communicable diseases such as HIV and AIDS, mental health conditions, chemical or alcohol dependency, laboratory results, medical history, treatment, or other related information.

My Rights

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that once the health information I have authorized to be disclosed reaches the recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.
I understand that this authorization will expire 180 days from the date signed unless I otherwise specify. I desire this authorization to be in effect until _____.
(Expiration Date)
I further understand that I may revoke this authorization at any time by notifying Ryan Ranch Medical Group in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patients Representative Relationship to Patient