Authorization for Release of Health Information

Patient's Full Name: ______________________________

Date of Birth: ______________ Social Security #: ______________

Phone #: (   ) ______________

Patient's Address: ______________________________

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Health Information Release **To / From:**

Physician's Name: ______________________

Address: ______________________

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Phone #: (   ) ______________________

Fax #: (   ) ______________________

Health Information Release **To / From:**

Dr. ______________________

Riser Medical Associates

2274 Hwy 43 South

Picayune, MS 39466

Phone: (601) 798-5798

Fax: (601) 798-1058

Reason for Release of Information: ______________________

Please note specific dates or information to be obtained: ______________________

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I understand that this authorization is valid for six months unless I notify Riser Medical Associates otherwise. I may revoke this authorization in writing at any time except to the extent that Riser Medical Associates has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Riser Medical Associates to the address or fax number above stating my intent to revoke this information. I understand that the records released may include information relating to HIV/AIDS; treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. This information will be requested in a prompt manner according to the standards of Riser Medical Associates provided all information has been supplied correctly.

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Patient Signature/Guardian   Relationship to patient   Date