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Medical Information Release Form

Patient: _____ Date of Birth: _____ Phone: _____

I, _____, the patient/guardian/healthcare power of attorney (circle one), authorize Ross Bridge Medical Center to:

[] Receive medical and other information from: _____

Or

[] Release medical and other information to: _____

Individual Name or Practice (Required)*: _____

Phone (required): _____ Fax: _____

Specify Email or Street Address: _____

City (Required): _____ State: _____ Zip: _____

** Please note that there may be a charge for printed records.

I would like records sent from the following doctors: (Please write names)

_____ or [] All of my doctors

Treatment dates to be disclosed: [] Entire [] Year to date [] Other _____

Purpose of the disclosure: [] Insurance [] Legal [] Continuing Care [] Personal [] Other _____

Specify description of the information to be disclosed:

[] History/Physical [] Progress Notes [] Hospital [] Correspondence

[] Labs & X-rays [] Insurance [] Miscellaneous [] All

Specific information NOT to be released: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the Ross Bridge Medical Center. I understand that my revocation is not effective to the extent that the persons or organization in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility of benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize Ross Bridge Medical Center to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release Ross Bridge Medical Center from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.

Patient/Patient Representative Signature

Date