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Authorization for Release of Information

Please make sure all blanks are filled in; failure to do so may prevent or delay release of information.
I hereby authorize the release medical records for:

Patient Identification

Name:_____

Address:_____

_____ Phone #: _____

SS#:_____ DOB: _____Maiden/Previous Name: _____

Provider releasing:
(What physician or facility Will be releasing information?)

Name: _____

Address: _____

Person receiving:
(Where is the information? Being sent?)

Name: _____

Address: _____

Information Requested or to be Viewed

For patient transfers Only 3 years of Info. Will be sent Unless otherwise Specified.

_____ Office Visit Progress Notes (date)
_____ Lab Data
_____ EKG/Heart reports
_____ X-Ray reports (if actual film is needed, request through the Radiology department)
_____ History and Physical (date)
_____ Discharge Summary (date)
_____ Operative Notes/Pathology (date)
_____ Immunization records
_____ Other: _____

*****If medical record contains any HIV information a separate release is required to be signed**

Reason for Release

_____ Consult – Continued medical care
_____ Legal
_____ Leaving the practice; please provide reasons or comments:
_____ Insurance Change (type)
_____ Moving out of the area
_____ Too old for pediatric practice
_____ Dissatisfied with technical skills of physician
_____ Dissatisfied with personal manner of physician
_____ Billing issues/concerns
_____ Wait time for appointments too long
_____ Wait time in office too long
Comments: _____
_____ Other: _____

Disclosure:

I understand that this authorization may be revoked in writing by me at any time; revocation will be honored unless request had previously been processed. Authorization will automatically expire 180 days after the date of signature. I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. Regional Rheumatology Associates, LLP is not legally responsible for any disclosure that may arise from requested information. Regional Rheumatology Associates, LLP is not authorized to disclose any medical information, which was obtained from other providers/facilities unless such disclosure is specially required or permitted by law. A $0.75 per page charge may apply for certain types of requests.

Signature of Patient or Legal Representative:_____ **Date:** _____

Relationship if Not signed by Patient: _____**Date:** _____

Approved Denied Number of copies _____ Amount Due $ _____

_____
Date processed / Karen Taluba, MGR, HIPAA Privacy Officer