

# 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