Medical Information Release Form: Rita Hancock MD (Provider)

Patient Name: ____ Date of Birth: __________________

Address: _________________________________ City: _________________ State: ______ Zip: _________

Home Phone: _________________________ Cell Phone: _________________

I authorize the use or release of the following health information for the patient described above:
[ ] Entire medical record, minus psychotherapy notes; [ ] Complete billing record;
[ ] Medical records from these dates: ______________; [ ] Billing record from these dates: _______________
[ ] Other:____

This release will be in effect beginning: ______/______/______ **and ending** ______/______/______.

Reason for request: [ ] Needed by healthcare specialist; [ ] Legal; [ ] Personal; [ ] Other: ____________

Records may be sent TO Rita Hancock MD FROM:

Name of entity: _________________________________; Address: _______________________________

Name of entity: _________________________________: Address: _______________________________

Records may be sent FROM Rita Hancock MD TO:

Name of entity: _________________________________: Address: _______________________________

Name of entity: _________________________________: Address: _______________________________

By signing below, I assert that I understand the following: Protected health information is health information that identifies me. The purpose of this authorization is to allow Provider to share my protected health information as set forth above. I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. If I refuse, my protected health information will not be used or disclosed by Provider except as otherwise permitted by law. Provider may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services from Provider. Subject to certain exceptions, I have the right to revoke this authorization at any time by sending a letter to Provider which gives my name, the date I signed this authorization, and states that I revoke the authorization to use my protected health information. The letter will not affect any actions taken in reliance of my previous authorization. This authorization may result in Provider disclosing my medical information to a recipient who could possibly later use or disclose the information without my authorization. Provider cannot control re-disclosure by Recipient. I may inspect or copy the information that will be disclosed or used for the purposes set forth in this authorization. I will receive a signed copy of this authorization form and may contact Provider to get a copy if I do not have one. Protected health information authorized for release may include records that indicate the presence of or regarding treatment of HIV/AIDS, sexually transmitted disease, and drug and/or alcohol abuse.

Signature of Patient or Patient's Representative: __________________________; **Date:** _______________

Printed Name of Patient or Patient's Representative: ____

(parent may NOT sign if patient is over 18 years old)

Description of Representative's authority (attach documentation)**:** ______________________________

(e.g. Parent of Minor, Legal guardian, Power of attorney)

This authorization is effective only if it is signed and dated. Unless I revoke this authorization prior to expiration, this authorization expires on ________ (or if this is left blank, one year after the date it is signed).