River Bend
Family Medicine

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Office (301)678-7007 Fax (301)678-7009

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

PATIENT NAME: _____DATE OF BIRTH_____

ADDRESS: _____SS#:_____

_____

I hereby authorize: Name: _____

Address: _____

_____

To release to: Name: _____

Address: _____

_____

Description of specific information to be disclosed:

Office notes from _____to _____

__Lab tests __X- rays __ultra sounds __CT scans __MRI __ immunization records

The purpose for the release of the above information is: ____Continued Care ___Legal reasons ___Insurance reason ___Other:

_____

I understand that:

- I may revoke or terminate this authorization by contacting River Bend Family Medicine and completing a Revocation of Authorization form.
- I may inspect or copy the protected health information to be used or disclosed.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected under HIPPA.
- I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed and my treatment will not be affected by my refusal to sign this authorization.

Signature of Patient :_____ Date signed:_____