PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

(To be filed in Patient's chart)

Frederick S. Fish, M.D.
Jeffrey M. Freed, M.D.
Ngo T. Hien, M.D. (in memoriam)
Susan M. Humphreys, M.D.
Steven E. Kempers, M.D.
Kimberly R. Kortuem, M.D.
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Jack C. Scott, M.D.
Jeffrey A. Squires, M.D.
Helen F. Tergin, M.D.
Roger H. Weenig, M.D.

Date:____________________

I hereby authorize____("releaser") to release medical records maintained while I was a patient of

____.

Please release the records to: ________________________________
(Name)

____
(Address)

____
(City, State, Zip)

Please release the following:

- ☐ Labs
- ☐ All Medical Records
- ☐ Special Tests
- ☐ Maps/Pictures
- ☐ Other please specify:____

____

The use or disclosure (as applicable) is for the following purpose(s):

- ☐ Personal Record
- ☐ Transfer of Care
- ☐ Consult
- ☐ Insurance Claim
- ☐ Copy for my Primary Physician
- ☐ Other____

Please release medical information on the following member:

________________________________ ________________
(Print Name) *(Date of Birth)*

________________________________ ________________
(Print Name) *(Date of Birth)*

________________________________ ________________
(Print Name) *(Date of Birth)*

I understand that I may revoke this authorization by sending a written request for revocation to releaser's Privacy Officer. If I revoke this authorization, releaser will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when the releaser discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

____
(Signature - All patients over 18 of age must sign)

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