Lawrence F. Rahall D.O. P.C.

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AUTHORIZATION FOR RELEASE OF INFORMATION

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION

NAME: First _______________ Middle _______________ Last _______________

Social Security Number_______________ Date of Birth _______________

I, THE UNDERSIGNED, HEREBY AUTHORIZE: (facility holding records)

Facility Name_______________ Phone_______________

Street Address _______________ Fax # _______________

City_______________ State _______________ Zip Code_______________

TO PROVIDE: facility where records are to be sent)

Facility Name_______________ Phone_______________

Street Address _______________ Fax # _______________

City_______________ State _______________ Zip Code_______________

With the Following Information:

- □Progress Notes
- □Drug/Medication Records
- □EKG Reports
- □Lab Results
- □Consultations
- □Accounting Disclosures
- □Emergency Room Reports
- □Discharge Summary
- □History and Physical Reports
- □Cardiac Catheterization Reports
- □Pathology Reports
- □Special Procedure
- □Operative Reports
- □Pulmonary Function Studies
- □Entire Record
- □Other _______________

From the following dates of service From: _______________ To:_______________

Purpose of Disclosure_______________

□ Check here to indicate that future healthcare services will not be sought at this location.

EXPRESSED AUTHORIZATION ^^**Signature Required**^^

I understand that my medical record may contain information related to :

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV.
- Psychiatric Care
- Treatment for Drug/Alcohol abuse

I **DO** give my consent for release of this information_______________

~or~ Signature Date

I **DO NOT** give my consent for release of this information_______________

Signature Date

Note: There will be a charge for the costs associated with copying your records. You will be informed of, and charged for these costs prior to the records being released.

This authorization for release of information is valid for 90 days from the date signed above, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information.

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REQUIRED: SIGNATURE OF PATIENT DATE

____

REQUIRED: SIGNATURE IF OTHER THAN PATIENT*** DATE

____

SIGNATURE OF WITNESS DATE

*****For Signatures other than the patient please attach required P.O.A. Documentation**

□ Patient given a copy of consent form

Records Sent _______________ By _______________

Date Signature of Employee