

RELEASE OF PATIENT INFORMATION

TO:

Name of healthcare provider

RE:

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Street Address

City, State and Zip Code

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose my full and complete protected medical information to _____.

Name of entity requiring the information

This disclosure should include:

Office notes; inpatient, outpatient and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries and test results.

Laboratory records and specimens; radiology records and films.

Prescription records and drug information related to such records.

Billing records, including statements, insurance claim forms, and statements of benefits for the period _____ to _____.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

Signature of Patient

Date