

### Authorization for Release of Medical Information

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_  
SS#: \_\_\_\_\_ Patient's phone #: ( ) \_\_\_\_\_

I authorize RMSCVA, PLC to release information to:

\_\_\_\_\_  
Name of Partner

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone #

The above mentioned provider/facility is authorized to release the requested health information for the following dates of service or range of events: this is in effect until revoked in writing by the patient.

**PURPOSE FOR THIS REQUEST:** (Check one.)  **Healthcare**  Insurance coverage  Personal  Other  
 Transfer of Care

**TYPE OF RECORDS REQUESTED:** (Check one.)  
 Discharge Summary  Psychiatric Evaluation  Office/Clinic Notes  **Lab/Pathology Reports**  
 History & Physical  Procedure/Operative report  Radiology Reports  Emergency Room Records  
 Consultation Report  Billing Information  Entire Records  
 Other \_\_\_\_\_

**I understand that:**

- These test results may affect the treatment recommendations and plans directed to my spouse/intimate partner.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- That the information being released may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV).
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I have read (or had read to me) the above authorization and I understand my rights with regarding to my protected health information

Print Name of Patient or Representative \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Guardian  Power of Attorney