Scott Kendrick, MD • Ashlee Fulmer, MD • Matthew Berke, MD • Cheryl Goyne, MD • Ross Lumsden, MD • Joseph Marino, MD

FAX: (866) 644-8086

Patient Name:		
Address:	Phone Number:	
City:	State:	Zip:
Social Security Number:	Date of Birth:	
Clinic/Hospital/Provider (Who has the information you want released?)	Name:	
	Address:	Fax Number:
	City: _____ State: _____ Zip: _____	
Receiving Party (Where do you want the information sent?)	Name:	
	Address:	Fax Number:
	City: _____ State: _____ Zip: _____	
Information to be Released (What do you want sent?)	Dates of Service: _____ TO _____	
	Types of services:	

1. I understand that authorization is voluntary. I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected.

2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by Federal Privacy Rules.

3. I understand that I may revoke this authorization at any time by notifying Health Care Provider in writing, but if I do it will not have any effect on uses or disclosures prior to the receipt of the revocation.

4. I understand that I may receive a copy of this authorization form after I sign it.

5. I understand that this authorization will expire one year from this date, or upon the following event.
_____

Signature of Patient or Patient Representative		Date
Printed Name of Patient Representative (if applicable)		Representatives Relationship to Patient