chathamcare pc

DAVID M. BLACKWELL, MD

Release of Medical Records

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: _____

Patient Address: _____

Persons/organizations providing the information:

Persons/organizations receiving the information:

Specific description of information to be used or disclosed. (Including date(s)): All medical records

Reason for use or disclosure of information: To obtain medical care from:

The person or organization providing the information will/will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. *[to be completed only if the authorization is for marketing purposes]*

I understand that I will not be denied health care or health plan coverage, as the case may be, if I do not sign this form. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
I understand that this authorization will expire on: _____
I understand that I may revoke this authorization at any time by notifying the person or organization providing the information in writing, but if I do it won't affect any actions taken before the revocation is received.

Signature of Patient or Patient's representative: _____ Date: _____
Printed name of Patient's representative: _____
Relationship of representative to Patient, if applicable: _____

FOR OFFICE USE ONLY
Revocation Date:
Processed By: Signature: _____