Real FAMILY MEDICINE

Release of Medical Information

Patient name: _____

Birthday: _____ Phone Number: _____

Address:_____

Other names you may have used:_____

Release from: _____

Release to: Dr. Jennifer Richards
Real Family Medicine
PO BOX 208
Loami, IL 62661

Please deliver PAPER records

What information is to be released?

____All Doctor / Specialty / Lab / imaging results / Immunizations

____ Psychiatric / substance abuse / sexual health information / developmental disability / abuse neglect / sexual assault / infectious diseases including HIV / Behavioral health _____(initial)

- I understand that I may ask to see information that is released
- That this authorization will expire in 12 months from signing
- I may revoke this authorization at any time with written notice to Real Family Medicine
- I authorize disclosure of my health information as listed above.
- Real Family Medicine is not responsible for any charges incurred for the reproduction of medical records by another health care provider or their contractors. These fees are the responsibility of the patient or patient's responsible party.

Signature of patient or legal representative Date

Print name of patient's representative and relationship Date

Witness Date