ROPHE' ADULT AND PEDIATRIC MEDICINE
AUTHORIZATION TO REQUEST/RELEASE MEDICAL INFORMATION

X Patient Name: _____ Soc. Sec. Number _____

X Date of Birth: _____ Alias/Maiden Name: _____

X I am the ____Patient ____Guardian ____Legal Representative and hereby authorize disclosure of medical information for the above named patient.

X Release record from:

Name: _____

Address: _____

Phone: _____

Fax: _____

Send record to:

Name: _____

Address: _____

Phone: _____

Fax: _____

Release the entire medical record? YES NO(Please specify): _____

X Release all information of the following diagnosis: _____

Release information on the following dates of treatment: _____

Exclude all information related to: _____

All information I hereby authorize to be obtained from this facility will be held in strict confidence. This general release authorizes the disclosure of any medical information, and unless specified above as an exclusion, this release includes the authority to release AIDs confidential information, records regarding the treatment of alcohol or dug abuse, and/or records regarding the treatment of psychiatric disorders.

I understand that unless otherwise limited by start or federal law by delivering a signed written withdrawal to personnel of Rophe' Adult and Pediatric Medicine, I may withdraw this consent effective upon receipt except to the extent that action has already been taken in or initiated in reliance thereon, and that upon the fulfillment of the above-state purpose (s), this consent will automatically expire. However, without express revocation, this authorization will expire ninety (90) days from the date of this signing.

I agree on behalf of myself, my heirs, and assigns, to release and hold harmless Rophe' Adult and Pediatric Medicine, and the releasing party, its employees, members of the medical staff, or their representatives from any and all liability in any manner for releasing this information in good faith, and from any and all damages, direct or indirect, caused thereby.

X _____
Signature of Patient Date

_____
Signature of Legal Representative Relationship Date