<u>High Rock Internal Medicine</u> <u>Authorization for Release of Medical Information</u>

Patient name:	Date of Birth:
Address:	Telephone:
I authorize the release of medical information as indicated below:	
From:	104 W. Medical Park Drive
What to release: Please choose the records you would like released	l:
[] All medical records [] Radiology reports [] Last 18 months [] Laboratory reports [] Other	[] X-ray CD
Note: The records listed below have special protection by laws. I au	
The diagnosis or treatment of AIDS, including results of HIV tests The diagnosis or treatment of drug and/or alcohol abuse	[] Yes
The treatment and/or consultation for mental health or psychiatric disorders	
Purpose of the release: Please indicate the reason for this release	
[] Transfer of care [] For another doctor/specialist [] Legal purposes [] To obtain disability	[] Personal Use [] Employment [] School
This authorization is only valid for one time use and for the purpose	stated.
*I understand this authorization can be revoked at any time according request must be made in writing and sent to the same place as the or plan is not conditioned on signing this authorization. *Once these records are released, the information is not protected by disclosed by the party who received these records. High Rock Interna are released for legal responsibility or liability for release of the above *I have read and understand this information. I am the patient or am document verifying authorization for the use or disclosure of the protection.	riginal request. Treatment, payment, enrollment in any health y High Rock Internal Medicine and may potentially be relabeled Medicine, its employees and officers, and attending physicians information to the extent indicated and authorized. authorized to act on behalf of the patient to sign this
**Our office uses an outside company called HealthPort to process records and bill you for this service, if applicable, based on regulater	
Signature of the patient	Date
Signature of legal representative and relationship to patient	Date

Date

Signature of witness