RIVER VALLEY MEDICAL GROUP
AUTHORIZATION FORM TO RELEASE MEDICAL RECORDS

Patient Name: ____ DOB: ______________________
Phone: ___________________________ Address: ____

I, the undersigned, authorize the release of, or request access to the information specialized below from the medical records of the above name patient.

Release Medical Records From:
____
____
____
____

Release Medical Records To:
____
____
____
____

Information to be Released:
History and Physical Laboratory/Pathology Reports Operative Reports Consultation Report
Radiology Reports Immunizations Hospital Discharge Other: _______________________________

Reason for Release of Records:
Transfer of Care Continuation of Care Insurance Disability Other: ___________________________

I attest that I am choosing to transfer to River Valley Medical Group of my own accord. I have not been solicited by any member of River Valley Medical Group to transfer.

Signature: ____ Date: ______________________
Patient or Legal Representative

As required by the Health and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy Policies. Your completion of this form means that you give permission for the uses and disclosure described below. I understand that my medical record may include information relating to sexually transmitted diseases; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

This authorization is effective for one year from the date of signing. I authorize future disclosures to the same individual and/or entities during this period.

Signature: ____ Date: ______________________
Patient or Legal Representative

Printed Name: ____
Printed Name of Patient or Legal Representative