RediClinic®

Authorization for Release of Medical Records

PATIENT INFORMATION (Please print)

Patient Name				Date of Birth / /
Address	City	State	Zip	Phone

RELEASE FROM: Name of facility releasing information

I authorize release of my medical records by RediClinic staff from RediClinic, LLC

9 Greenway Plaza, Suite 2950, Houston, TX 77046

RELEASE TO: Name of patient, physician, or facility receiving information

Please provide my medical records: by mail [ ] by fax [ ]

Send to:				Phone
Circle one: patient, parent, guardian, conservator, physician, or patient representative				
Address	City	State	Zip	Fax

RELEASE INFORMATION

Reason: [ ] Change of insurance [ ] Moving out of area	[ ] Transfer of care [ ] Specialist consult	[ ] At request of Patient [ ] Legal

Please release the following (*check all that apply **and** provide dates of service*):

Medical Chart [ ]	/ /	Lab Report [ ]	/ /
Billing Record [ ]	/ /	Other (describe) [ ]	/ /

> Incomplete information will delay processing.

> Use of this information for any other than the stated purpose is prohibited.

> This information is for the use of the designated recipient only.

AUTHORIZATION

I authorize the release of all information indicated and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I understand that RediClinic may not condition treatment on my completion of this authorization form. I understand that to the extent any recipient of this information is not a "covered entity" under state of federal law, the information may no longer be protected once it is disclosed to the recipient and may be subject to re-disclosure by the recipient.

	YES	NO	Initials
I authorize the release of my HIV/HTLV/Aids status.			

Signature	Date / /
Circle one: patient, parent, guardian, conservator, physician, or patient representative	
Printed Name	

Note: This authorization is valid for 90 days. The signer may revoke it at any time by submitting a written request to RediClinic Privacy Officer, 9 Greenway Plaza, Suite 2950, Houston, TX 77046. The revocation will be effective upon receipt except to the extent RediClinic has already relied on the authorization.