

Recordkeeper RMS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

- 1 Patient Name _____
- 2 Home Address _____
- 3 Date of Birth _____
- 4 Phone number _____
- 5 Address of office last seen in _____
- 6 Year last seen _____
- 7 Where to send File _____

I hereby authorize Recordkeeper RMS to release the following protected health information from my medical records. I understand that the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature of patient

Date

*Please mail this signed form along with a check or Credit card for \$15.00 to:

Credit Card Info

Name on Card	_____	Card type	<u>Visa / Mast</u>
Card #	_____	Exp Date	_____
Security Code	_____	Zip Code	_____

Recordkeeper RMS
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