RHAD Healthcare, LLC

Authorization to Release Medical Records

Name of Patient:_____ Date of Service:_____

Date of Birth:_____ Social Security Number:_____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

INFORMATION TO BE RELEASED OR ACCESSED:

☐History & Physical	☐Consultation Report	☐Emergency Report Record
☐Operative Reports	☐Discharge/Death Summary	☐Face Sheet
☐Lab/Path Reports	☐ X-Ray Reports/Images	☐Other:_____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

RHAD Healthcare, LLC FAX (623)-505-9755

24654 N. Lake Pleasant Pkwy. STE 103-104 Peoria, AZ 85383

FROM:

(Name)

(Address)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date_____ Signature:_____

_____

Printed Name

_____

Relationship to Patient