Jacob H. Rinker, MD, FACS
Trisha Rinker , APRN
Paul Bezas, PA-C, MPAS
Christopher McDonald, AGACNP-C
Lindsay McDonald, NP-C
Landi Lowell, MD, CIME
Lindsey Lang, FNP

Tax ID#: 85-2854693

MEDICAL RECORDS RELEASE FOM

Patient Name: _____ **Previous Name:** _____

Date of Birth: _____ **Phone Number:** _____

Send Records To:
Provider/Organization Name

_____
_____

Records to Be Released From:
Provider/Organization Name

_____
_____

Purpose of Disclosure: Patient Care ___ Self ___ Other ___

Approximate date of treatment and records to be released: _____

[ ] History/Physical Wellness
[ ] Radiology Reports/Films
[ ] ER Reports
[ ] Pathology Reports
[ ] Discharge Summary
[ ] Operative Reports
[ ] Psych-Social History
[ ] Psychiatric Evaluation

I understand that if the authorization includes disclosure of any Psychiatric, alcohol, and or drug abuse records, the records are protected by virtue of the provisions of Federal Regulations 42 C.F.R. Part 2.

This information has been disclosed to you from the records whose confidentiality is protected for Federal Law. Federal Regulations (42 C.F.R. Part 2) prohibits you from making any further discloser of it without specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Also, please be aware that once we disclose these records per your instructions the information is subject to redisclosure and may no longer be protected by HIPAA. ***INITIAL*** _____

I do hereby acknowledge that I have read and am familiar with and fully understand the terms and conditions of this authorization. If Patient is unable to sign, please indicate such and the authority for the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the records have not already been disclosed. Please see our Notice of Privacy Practices for instructions of how to revoke this authorization. If release of information is to include Psychiatric, Alcohol, Drug Abuse, or HIV results initials are required. ***INITIAL***_____

This authorization expires on _____. If no date the authorization will expire 12 months from the date of release.

_____ _____
Print Patient Name or Legal Representative | Relationship to Patient

_____ _____
Signature of Patient or Legal Representative | Date

_____ _____
Witness Signature | Date