Richard Bingham, M.D.
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Authorization for Release of Information (ROI)

Name of Patient **Birthdate**

I, the undersigned, authorize the release of confidential medical records for the above named patient with the Person or Organization listed below (check one or both boxes):

- ❒ **FROM Dr. Bingham TO** (person/organization named below):
- ❒ **TO Dr. Bingham FROM** (person/organization named below):

Person or Organization (e.g., Doctor, Hospital, Insurance Co., Attorney, Self, etc.) **Phone/Fax Number**

Address (Street, City, State and ZIP)

This confidential information may be shared for the following reasons:

- ❒ Continuing Medical Care
- ❒ Other:_____

I understand that all records from Dr. Bingham are considered mental health records, may include alcohol/drug use and cannot be disclosed without my written authorization, except where otherwise permitted by law. My signature (below) allows Dr. Bingham to release information with the person/organization named above until one year after the file closes with Dr. Bingham. 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 this authorization. I understand that all revocations must be made in writing and delivered to Dr. Bingham by certified mail or confirmed fax (as above).

Name (Patient or Legally Authorized Representative) **Relationship to Patient** (e.g., self, parent)

Signature **Date**