Dr. Richard Bingham M.D
Board Certified Pediatric & General Psychiatry

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Authorization to Release Confidential Information

Name of Patient_____ **Birthdate** _____

I, the undersigned, authorize the release of, or request access of my confidential medical record(s) of the above mentioned patient from Dr. Bingham to the Person or Organization listed below.

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone/Fax Number

_____

Address (Street, City, State and ZIP)

This confidential information may released for the following reasons:

Continuing Medical Care

Other: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I 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 (12) months from the date of my signature, unless I revoke the authorization prior to
that time

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative