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Marie A. Bianchi, MSN,ACNP Liesl M. Hand, RPA-C
Theresa Schwartz, ANP-C Carol B. Strauss, RPA-C

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ______________________________
Address: ______________________________
City/State/Zip Code: ______________________________
DOB: ______________ Patient's Phone# ( )
Date of Request: ______________ **Expiration of request:**

☐ I authorize RCRS *to* ***RELEASE information to:***	OR	☐ I authorize RCRS *to* ***OBTAIN information from:***
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Phone#/Fax (include area code)		Phone#/Fax (include area code)

Purpose for request: (Check One) ☐ Health Care ☐ Insurance Coverage ☐ Personal ☐ Other

Type of Records Requested:
☐ History & Physical ☐ EKG ☐ Consultation ☐ Lab Reports ☐ X – Rays
☐ CT Report ☐ MRI Reports ☐ Pathology Report ☐ Colonoscopy Photos
☐Other ______________________________

I understand that I may revoke, in writing, this authorization at any time, but revocation will not apply to information that has already been released under this authorization. I understand that if the party authorized to receive the information is not a health care provider; the information may no longer be protected by federal privacy regulations. This authorization for release of information expires (check one: specify date or condition, if applicable):

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records. 75₵/page prior to records release for providing copies of above information but will not exceed $30.00

Patient Signature (or responsible party) **Date** **Required Witness Signature** **Date**

If "Responsible Person" signed this form, describe Responsible Person's authority to act for the patient ______________