Recordkeeper RMS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1 Patient Name

_____

2 Home Address

_____

3 Date of Birth

_____

4 Phone number

_____

5 Address of office last seen in

_____

6 Year last seen

_____

7 Where to send File

_____

I hereby authorize Recordkeeper RMS to release the following protected health information from my medical records. I understand that the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____

Signature of patient Date

*Please mail this signed form along with a check or Credit card for $15.00 to:

Credit Card Info

Name on Card _____ Card type Visa / Mast_

Card # _____ Exp Date _____

Security Code _____ Zip Code _____

Recordkeeper RMS
57 Littlefield Street
Avon, Ma 02322