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RELEASE OF MEDICAL INFORMATION

We will need to access your private healthcare information for the purpose of treatment, payment, and operations. In using this information our office will comply with state and federal laws pertaining to your privacy rights, including the HIPPA act. We will disclose your information only when sharing the information for the purpose of treatment, payment, or operations. This information may be shared with but is not limited to your primary care physician[s], referring physician [s] and specialist [s] who will be involved in your medical care or treatment.

In order to obtain medical records from another physician or medical institution, or to provide medical records as stated above please sign below in acknowledgment of your consent.

PLEASE SIGN IN ACKNOWLEGEMENT THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____