White River Clinic: Privacy Release Form

Patient Name: _____ Date of Birth: ____/_____/_____

Authorization

1. I, _____, hereby authorize

2. Name of person _____

   Street Address: _____

   City, State, Zip: _____ Telephone ( )

3. To release and discuss the following information :
   - ☐ Complete Records
   - ☐ Impatient Care
   - ☐ Outpatient care
   - ☐ X-Ray Results
   - ☐ Treatment Plan

This information is being released at my request

Signature

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by laws

I understand that this consent is subject revocation, in writing, at any time, unless action based on it has already begun.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signature: _____ Date: _____

Witness: _____ Date: _____