

## Authorization for release of information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Persons/Organizations <i>providing</i> the information	Persons/Organizations <i>receiving</i> the information
	<b>Barrie W. Ross, MD</b> Ross Rehabilitation PC 7301 Jefferson NE, ste E Albuquerque, NM 87109 Fax: 505-341-1495

*Please specify what records should be released:*

All records  
All records between the dates of \_\_\_\_\_ and \_\_\_\_\_  
Records pertaining to \_\_\_\_\_

Specific description of each purpose of the use or disclosure of information:

\_\_\_\_\_

\_\_\_\_\_

### **The patient or the patient's representative must read and initial the following statements:**

1. I understand that my healthcare and the payment for my healthcare will not be affected if I do not sign this form. INITIALS: \_\_\_\_\_
2. I understand that I may see and copy the information described on this form if I ask for it and that I may receive a copy of this form after I sign it. INITIALS: \_\_\_\_\_
3. I understand that this authorization will expire on \_\_\_\_\_ INITIALS: \_\_\_\_\_
4. I understand that I may revoke this authorization at any time by notifying Dr. Ross in writing, and if I do, it will not have any effect on any actions taken before Dr. Ross received the revocation. INITIALS: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's representative (Form **MUST** be completed before signing) \_\_\_\_\_ Date

Printed name of patient's representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_