

DRS REITER HILL JOHNSON AND NEVIN

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT'S NAME _____
DATE OF BIRTH _____
DAYTIME PHONE NUMBER _____
SOCIAL SECURITY NUMBER _____

WHO DO YOU AUTHORIZE TO RELEASE YOUR MEDICAL INFORMATION. (WHO IS SENDING YOUR RECORDS?)

NAME OF PERSON MAKING REQUEST TO RELEASE PATIENT INFORMATION

NAME OF PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION. (WHO IS RECEIVING YOUR RECORDS?)
PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW IF ALL INFORMATION IS NOT INCLUDED THE MEDICAL RECORD WILL NOT BE RELEASED.

NAME OF DOCTOR OR INDIVIDUAL AUTHORIZED TO RECEIVE MEDICAL RECORDS.
NAME: _____

FAX# _____

MAILING ADDRESS: _____

DESCRIPTION OF MEDICAL RECORDS TO BE RELEASED (LAB WORK, OFFICE VISITS, ETC).

THIS SECTION MUST BE COMPLETED IF REQUEST FOR DISCLOSURE IS MADE BY SOMEONE OTHER THAN THE ABOVE NAMED PATIENT:

Purpose for disclosure of information: _____

I understand that the person I am authorizing to receive my protected health information may receive compensation for doing so _____ (please initial).

I understand that I may refuse to sign this authorization and that if I do so, it will not affect my ability to obtain treatment or payment or eligibility for benefits and that I may inspect or copy any information used or disclosed under the authorization _____ (please initial).

I understand that if the party receiving this information is not a healthcare provider or health plan subject to the federal privacy regulations that the information described above may be redisclosed and no longer protected by the private regulations _____ (please initial).

I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred _____ (please initial).

This authorization becomes effective on: ___/___/___ and will expire ___/___/___.

Reason for your request: _____

Patient (or Representative) Signature

Date

Name of Personal Representative (please print)

Relationship to Patient

Mail or fax authorization to:

Drs Reiter Hill Johnson and Nevin 1145 19th Street, NW #410 Washington DC 20036 fax # 202-296-9784
5550 Friendship Blvd #210 Chevy Chase, MD 20815 fax # 301-718-8330
407 N. Washington Street, #105 Falls Church, VA 22046 fax# 703-533-9401