Cramer Family Clinic℠

Print Form

2301 South Highway 65, Suite 3
Marshall, Missouri 65340
Ph (660) 886-4665 Fax (866) 691-6075

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Cramer Family Clinic to release / obtain copies of certain medical record information as specified below:

Patient's Full Name: _____

Date of Birth: _____ Social Security Number: _____

Dates of Treatment: _____

I request only the following information to be released/obtained:

- ☐ Medical Record Set
- ☐ Emergency Report
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory (specify): _____
- ☐ Other (specify): _____
- ☐ EKG
- ☐ Itemized Billing Statement

Information is to be released to/obtained from: _____
(Physician/Institution/Agency)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

For the purpose of: _____

I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME PRIOR TO ACTION BEING TAKEN. I UNDERSTAND THIS AUTHORIZATION WILL EXPIRE NINETY (90) DAYS FROM THE DATE IT IS SIGNED. I UNDERSTAND THAT IF I WANT TO CANCEL/REVOKE THIS AUTHORIZATION, I MUST MAIL, FAX OR BRING A LETTER IN PERSON TO THE ADDRESS OR FAX LISTED AT THE TOP OF THIS FORM, STATING THAT I WANT TO CANCEL THIS AUTHORIZATION.

I UNDERSTAND THAT CRAMER FAMILY CLINIC CANNOT MAKE ME SIGN THIS AGREEMENT AS A CONDITION TO OBTAINING MEDICAL TREATMENT.

PROHIBITION ON REDISCLOSURE. Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law regulations and may no longer be deemed Confidential. I permit the release of all information indicated above to including test results, diagnosis, and treatment information. I understand the information released may include psychiatric treatment, may indicate the presence of AIDS/HIV or other communicable diseases, drug and or alcohol usage or drug and or alcohol treatment.

Ifyou are signing on behalf ofa patient for whom you are the legal guardian or personal representative, you must produce a certified copy ofyour appointment as legal guardian or personal representative. lfyou are signing on behalf of a patient who is deceased, you must provide a copy ofthe certified patient's death certificate.

This authorization is being presented pursuant to litigation: (please check the appropriate block) ☐ Yes ☐ No

Signature of Patient/Legal Guardian/Personal Representative _____ Date _____

If someone else signs on behalf of the patient, state your relationship to the patient _____ Date _____

Witness _____ Date _____

If_this Authorization is being presented pursuant to litigation, complete this section.

If_this Authorization is being completed pursuant to litigation, please note that this Authorization includes medical records, reports and other medical documents in your possession which relate to any prior or subsequent complaints, injuries, illnesses, or other conditions involving the same parts ofthe body and the same or similar conditions as described below. This Authorization includes but is not limited to records of all examinations, treatments and tests, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRis and CT scans and post-mortem records, ifapplicable, PROVIDED that the examinations, treatments and/or tests involve or relate to complaints, injuries, illnesses or condi-tions pertaining to the following alleged injury:

(insert allegation from petition which describes injured part(s) of_body)

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that ofthe health care provider. However, disclosure that exceeds the scope ofthis authorization may subject the health care provider to civil liability.

This authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental doc-uments is sufficient, and no additional authorization is required.

[The patient further requests that the health care provider supply complete copies of_all documents produced pursuant to this authorization to patient's attorneys, _____, at their expense. (if desired by Plaintiffs counsel)]

Date/Time of Release: _____

Release ofInformation Clerk: _____