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Authorization to Release Medical Information

This document authorizes RecordSourceMD to review, inspect, copy, and deliver medical records and information regarding the following patient:

Which Doctor's Records are you requesting: _____

Patient Name: _____
Date of Birth: ____/____/_____
SSN: _____-_____-_____
Address: _____
City, State, Zip: _____ , _____ _____
Contact Phone: _____

(If different than above)

Records Delivery Address: _____
City, State, Zip: _____ , _____ _____

Please release any and all medical records included but not limited to:

- ❑ Medical Records
- ❑ X-Rays
- ❑ Billing

For the period: ___/___/_____ to ___/___/_____

Please remit payment with this authorization by mail to the above address.
Records will not be released until payment and a signed authorization are received.
If no payment amount is specified, please contact RSMD.

I understand that I have the right to:

1. Receive a valid copy of this authorization.
2. Refuse to sign this authorization and that doing so will NOT affect the manner in which I receive treatment, enrollment in my health plan, and eligibility for benefits or payment.
3. Restrict what information is disclosed by this authorization
4. Inspect a copy of the information that is disclosed by this authorization
5. Any information that is used or distributed due to this authorization
6. Revoke this authorization by sending a written notice to the custodian of records and that revocation w ill not affect the custodian's prior reliance on this authorization.

I understand that the information disclosed in this authorization can potentially be re-disclosed to additional parties and no longer protected for reasons beyond our control.

Signed: _____

Date: ____/____/_____

Unless otherwise revoked, this authorization expires on: ___/___/_____ (if no date is indicated, this authorization will expire one year from the date this authorization is signed)

Photocopies of this authorization are considered valid as the signed original.

Records will be mailed on a CD