RINDFLEISCH FAMILY PRACTICE

Request for Medical Records

To be completed by the patient or the patient's authorized representative: Patient's Name Patient's SSN Date of Birth Street Address City State Zip Code Telephone To be completed by the doctor if he sees fit to request medical records from another provider: I hereby authorize the below referenced provider to I hereby authorize the following person or organization to release confidential and protected health information, as receive this information: described below: Name Rindfleisch Family Practice 3155 Channing Way, Ste. A Organization Name Idaho Falls, ID 83404 Street Address Citv State 208-522-6044 Telephone 208-523-4862 Fax Telephone Fax Specific Information to released/disclosed is as follows: Patient information for visits of Idaho Physical Medicine and Rehabilitation PA providers Billing records - statements of charges and payments ___ Specific Lab/x-ray/Report: ___ All records, or related to the period: and ___ If you do not wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and or alcohol abuse, mental illness or psychiatric, please initial here Unless initialed here this information is deemed permissible to release. This authorization is valid for 180 days, unless revoked or expires on: (Expiration Date) **Notice to Patient:** When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at IPMR. You do not have to sign this authorization and that your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be considered to be the same as a signed original. Patient's Signature Date Print Patient's Name Signature of Parent or Personal Representative Date Print Parent or Personal Representative Name