

# Hoffman Geriatric Services SC

## Release of Medical Information

### I Authorize:

\_\_\_\_\_  
Individual or Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State Zip Code

### To Exchange With:

\_\_\_\_\_  
Individual or Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State Zip Code

The following information for the dates starting \_\_\_\_\_, and ending \_\_\_\_\_.

- Physicians Progress Notes
- History and Physical/Discharge Summary
- Laboratory and X-ray results, specifically CT or MRI of Head, CBC, Comprehensive Metabolic Panel, Vit. B-12, TSH

(If not specified please send all for the time frame listed)

- Medication and Problem List
- Power of Attorney and/or Living Will documents
- AODA and/or psychiatric reports
- other documents as specified below:

oral and written communication \_\_\_\_\_

If necessary this information may be conveyed by facsimile (fax) machine  yes  no

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Hoffman or another member of the clinic staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the time of this document or on the following date, event or condition:

\_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary and I need not sign this form in order to assure treatment. I understand that I may inspect or receive a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy standards. If I have questions about disclosure of my medical records I can contact my physician or a member of the clinic staff to discuss it.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Power of Attorney or Guardian (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_

