Martin D. Rudloff, MD, PC

851 East Fifth Street, Suite 124
Washington, MO 63090
(636) 390-8880
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INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

____

(Patient Name / Names) (D. O. B.) (Telephone Number)

____

(Street Address) (City, State) (Zip Code)

RELEASE RECORDS <u>TO / FROM:</u>	**RELEASE RECORDS <u>FROM / TO:</u>**
Martin D. Rudloff, MD, PC	________________________________
851 E. Fifth St., Ste. 124	________________________________
Washington, MO 63090	________________________________

INFORMATION TO BE RELEASED:
________ All Clinical Records ___________ Immunization Records _________ Other (specify)______________________

REASON FOR RELEASE:
_________ Changing Physicians _________ Consultation/Referral from our Physician _________ Moving Out of Area
_________ Other (specify): ____

I understand that the specific information to be released may include, but not limited to: history, diagnoses, immunization record and/or treatment of drug or alcohol abuse, mental illness or communicable disease, including human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS). I authorize the release of this specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation.

This authorization expires 90 days from the date of signature, unless I specify otherwise or revoke my authorization. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I HAVE READ AND UNDERSTAND THIS CONSENT.

____

(Signature of Patient or Parent / Executor / Legal Representative) (Date)

____

(Signature of Witness) (Relationship to Patient)

<u>There is a **$20.00** Fee to Release and Copy these Medical Records.</u>

Paid by (circle one): Cash / Check # _______________ / Visa / MasterCard Date Paid: ____________________________

Date Records Mailed / Picked up: _______________________________________ by _________________________________.

(revised 01/06/10) Initials: _______________