



RediClinic[®]

Authorization for Release of Medical Records

PATIENT INFORMATION (Please print)

Patient Name				Date of Birth / /	
Address	City	State	Zip	Phone	

RELEASE FROM: Name of facility releasing information

I authorize release of my medical records by RediClinic staff from RediClinic, LLC
 9 Greenway Plaza, Suite 2950, Houston, TX 77046

RELEASE TO: Name of patient, physician, or facility receiving information

Please provide my medical records: by mail by fax

Send to:	Phone
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Circle one: patient, parent, guardian, conservator, physician, or patient representative

Address	City	State	Zip	Fax
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RELEASE INFORMATION

Reason: <input type="checkbox"/> Change of insurance <input type="checkbox"/> Moving out of area	<input type="checkbox"/> Transfer of care <input type="checkbox"/> Specialist consult	<input type="checkbox"/> At request of Patient <input type="checkbox"/> Legal
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Please release the following (*check all that apply and provide dates of service*):

Medical Chart <input type="checkbox"/>	/ /	Lab Report <input type="checkbox"/>	/ /
Billing Record <input type="checkbox"/>	/ /	Other (describe) <input type="checkbox"/>	/ /

- > Incomplete information will delay processing.
- > Use of this information for any other than the stated purpose is prohibited.
- > This information is for the use of the designated recipient only.

AUTHORIZATION

I authorize the release of all information indicated and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I understand that RediClinic may not condition treatment on my completion of this authorization form. I understand that to the extent any recipient of this information is not a "covered entity" under state or federal law, the information may no longer be protected once it is disclosed to the recipient and may be subject to re-disclosure by the recipient.

	YES	NO	Initials
I authorize the release of my HIV/HTLV/Aids status.			

Signature	Date / /
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Circle one: patient, parent, guardian, conservator, physician, or patient representative

Printed Name

Note: This authorization is valid for 90 days. The signer may revoke it at any time by submitting a written request to RediClinic Privacy Officer, 9 Greenway Plaza, Suite 2950, Houston, TX 77046. The revocation will be effective upon receipt except to the extent RediClinic has already relied on the authorization.