Namaste Health Care
Ashland, MO 65010
Tel (573) 657-7330 Fax (573) 657-1772

Authorization to Release Medical Information

Patient Name:_____Date:_____

Date of Birth: ____ - ____ - ____ Social Security #:_____
month day year

I HEREBY AUTHORIZE
Name of agency:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____ Fax:_____

_____TO RELEASE TO ____TO OBTAIN FROM

Namaste Health Care medical records as indicated below, regarding the diagnosis and records of any treatment or examination rendered to me, including, but not limited to, HIV related information, mental health records and substance abuse records.

I specifically authorize release of the following information:

☐ Entire Medical Record, **or** (check the appropriate box(es))

☐ Progress Notes

☐ Hospital Records: for these dates_____OR ☐ All dates

☐ Lab Reports ☐ X-Ray Reports ☐ Operative Notes

☐ History & Physical ☐ Consultation Notes ☐ Discharge Notes

☐ Other_____

For the purpose of ☐ Transfer of Care ☐ Coordinating Care

☐ New Primary Physician ☐ Legal Matters

I release you from all legal responsibility or liability that may arise from the release of this information. I know that I have the right to revoke this release at any time by notifying Namaste Health Care in writing, and it will be effective on the date of notification except to the extent that Namaste has already acted upon such authorization.. I know that information used or disclosed under this authorization may be subject to redisclosure by the recipient. I understand that my health care and payment for my health care will not be affected if I do not sign this authorization form. I have been offered a copy of this signed authorization form.

Signature of Patient or Legal Guardian:_____Date:_____

Signature of Witness:_____Date:_____