Robin Dale MD
Family Medicine

Information Release Form

Patient's Name _____ Birth date _____

Address _____ Phone # _____

I hereby authorize _____ to release information specified below from my
Name of Hospital / Physician / Facility
medical records covering the dates of services _____ to _____.

_____
Address of releasing Hospital / Physician / Facility City State Zip

The information checked (X) below is to be released to:
Robin Dale MD, Family Medicine, 8369 Florida Blvd, Suite 5, Denham Springs, LA 70726.
Fax is the most secure means of communication. 225.380.1772

Check off items being released:

____	Discharge Summary	____	Pathology Reports	____	X-ray Report
____	Discharge Instructions	____	ER Record	____	Labs
____	History and Physical	____	Operative Report	____	Endoscopy Report
____	Consultations	____	Entire Record	____	EKG / Echo / Cath
____	Progress Notes	____	Other _____		

Purpose for release (circle one): Medical Insurance Other

_____ Date _____
Signature of Patient or Guardian / Parent / Power of Attny

The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, psychiatric treatment, and genetic testing (defined in the Genetic Information Non-Discrimination Act of 2008 – GINA, section 201 7 A and B). To authorize release of this information, please read and sign the following:

I, _____, authorize the release of **alcohol and/or drug abuse** treatment and information.
I, _____, authorize the release of **HIV test results** and/or HIV treatment information.
I, _____, authorize the release of **psychiatric** information.
I, _____, authorize the release of **genetic testing** information.

In authorizing the release of the confidential information identified above, I hereby waive all restrictions r privileges imposed by law and release Robin Dale MD, Family Medicine and it's staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation, or communication. I do understand that the information that is being released may be subject to redisclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment, or eligibility for benefits ay not be conditioned on signing this authorization.
This authorization may be revoked in writing at any time, except to the extent that Robin Dale MD, Family Medicine and its affiliates have already taken action in reliance on it. Letters to revoke this authorization should be sent to Robin Dale MD, Family Medicine at the address or fax # listed above.