RIVER BEND
FAMILY PSYCHIATRY, PLLC

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**Authorization to Use/Disclose Health Care Information**

I authorize Janet Zoch MD to do one of the following: (Circle one)

**Release Records to:** *OR* **Receive Records From:** *OR* **Release and receive records:**

Name:_____
Address:_____
City, State:_____ Zip Code:_____
Phone:_____
Fax:_____

This request applies to the following protected health information:

____ **All information**
____ Appointments only ____Billing Reports
____Medication only ____Laboratory Reports
____ Office Notes
____Other – please specify:_____

During the following time period or dates:_____

I am requesting the release of this information for the following reason *(circle one)*:

**Transfer of care** **Coordination of Care** **Other: _____**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

This authorization will remain in effect until patient revokes this authorization in writing by sending written notification to my office address. However, your revocation will not be effective to the extent I have taken action in reliance on the authorization or if this authorization was obtained as a condition of insurance and the insurer has a legal right to contest a claim.

**Name of Patient:_____ DOB:_____**

**Name of Guardian (if applicable): _____**

**Relationship: _____**

**Signature: _____ Date:_____**