Realm HealthCare Inc. **STAT**

Authorization for Release of Medical Information

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
Name of Health Care Provider	Name of Health Care Provider
Name of Medical Office/Hospital	Name of Medical Office/Hospital
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone:(_____)_____ Fax:(_____)_____	Phone:(_____)_____ Fax:(_____)_____

I hereby authorize_____ to release the medical information as indicated below to the health care provider, or person I have indicated above.

Release records regarding:

Patient Name:_____ Date of Birth_____

Address:_____ Phone Number: (_____)_____

This authorization shall become effective immediately and shall remain in effect one year from the date of the signature. This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. I understand that the requester may not lawfully further use/disclose the information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Check the box indicating the type of information that is to be released:

- ☐ All medical information (from _____to _____)
- ☐ Upper Endoscopy reports
- ☐ Colonoscopy reports
- ☐ Pathology reports
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Provider notes

I request that the health information released pursuant to this authorization be used for only for the following purposes:_____

I have the right to request and receive a copy of this authorization, it is for me to keep.

Date	Signature of Patient/ Representative	Indicate Relationship (If signed by other than the patient)

A copy of this authorization is valid as an original.