

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Request:** _____

Date of Birth: _____ **Social Security Number:** _____

Address: _____

I authorize Jonathan R. Stieber, MD to release information to: _____

Name of Provider or Facility: _____

Address: _____

Telephone: _____ Fax: _____

I authorize Jontham R. Stieber, MD to obtain information from: _____

Name of Provider or Facility: _____

Address: _____

Telephone: _____ Fax: _____

All Records	<input type="checkbox"/>
Radiological Report(s)	<input type="checkbox"/>
Operative Report(s)	<input type="checkbox"/>
Change of Physician	<input type="checkbox"/>

Other: _____

Please provide a current telephone number in the event we need to contact you.

Signature of Patient or Representative: _____ Date: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.