RESTORATION HEALTH

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Spanish Fort, AL 36527
(251) 348-2227 Fax (251) 216-4343

Dr. J. Clay Rainer, M.D.
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# *MEDICAL RECORDS RELEASE*

Patient Name :_____ Date of Birth_____

I hereby authorize Restoration Health

*To obtain records from: _____

At this address: _____

Phone: _____ FAX:_____

Purpose for release:

_____Legal _____Insurance _____Treatment _____Other

Date of Services to be released from: _____ to _____

Types of records to be released (office notes, procedure notes, labs, imaging, all records, etc.)

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AUTHORIZATION TO RELEASE PROTECTED

"I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease."

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_____ _____

Signature of Patient/Legal Representative Date

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on year from the date signed below. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability of disclosure of the above information to the extent indicated and authorized herein. I Acknowledge that I have read and fully understand this authorization as it applies to me. By my signature, I authorize execution of the terms of this document.

_____ _____

Signature of Patient/Legal Representative Date