WOUND CARE and HYPERBARICS

Medical Information Release Form

Patient:

Full Legal Name: _____ Date of Birth: _____Gender: M F

Home Address: _____

Information for Medical Treatment:

Name of Practice: **R3 Wound Care & Hyperbarics**

This Authorization shall be in force on _____ and remain effect until _____, I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon.

Authorization to Release Medical Information

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of **R3 Wound Care and Hyperbarics** to release or disclose any protected health information to _____, to include all or only:

○ **Medical History** ○ **Insurance Records** ○ **Billing Information**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my Signature below. I am entitled to a copy of this authorization.

Patient's or Legal Guardian's Signature: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)