Elisabeth Potter, MD, PLLC

Release of Information Form

Patient Name ____ Birth Date ______/______/________

The patient listed above hereby authorizes Elisabeth Potter, MD, PLLC to

❑ Request information from ❑ Send information to ❑ Discuss information only with

❑ Patient (Self) ❑ Other ____

Address ____ Zip Code _____________

Phone (_____) _____-_______ Fax (_____) _____-_______

REGARDING: ❑ Demographics & Medical Records ❑ Billing & Financial Records

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TIMEFRAME: ❑ Entirety of Care ❑ Date Range _____/_____/_____ to _____/_____/_____

PURPOSE: ❑ Medical Care ❑ Insurance ❑ Other ____________________________________

I understand that:

- By signing, I am authorizing the release of private information which may include information protected under HIPAA regarding communicable diseases or mental illness
- If the receiving party is not subject to privacy laws, the information being released may not be protected and could be subject to an unauthorized disclosure, for which this provider and all of those associated with the practice would not be held liable
- I have the right to review any disclosed information according to the Privacy Practices
- The duration of this authorization will be for one year unless revoked in writing
- If revoked, it will not apply to any information that has already been released
- If revoked, it will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy
- There may be a fee associated with requesting medical information
- Authorizing the disclosure of this information is voluntary; I may refuse this authorization, but it could hinder my healthcare provider's ability to properly assist in my treatment

Patient Signature (or authorized person) ____

Relationship to Patient ________________________________ Date ___________________________

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