ROLLA FAMILY CLINIC

9 am-9 pm

Walk-In & Primary Care

P:(573)426-5900 F:(573)426-4466

Oluyomi Olusanya MD
Board certified in Internal Medicine Emergency Medicine

Shaundelle Olusanya DNP
Board certified in Family Practice

Dawn Tope FNP
Board Certified in Family Practice

Alexis West FNP
Board Certified in Family Practice

RECORD RELEASE

PATIENT IDENTIFICATION

NAME ______________________ DATE OF BIRTH ______________

STREET ADRESS ______________________

CITY STATE ZIP CODE ______________________

TELEPHONE NUMBER ______________________

Information to be released-Covering the periods of Health Care

From (date):____________________ To (date):________________________

Please mark type of information to be released.

____ Complete Health Record ____ Radiology Reports

____ Laboratory Test Records ____ Statements of charges/payments

____ Other ____

Purpose of Request

____ Treatment or Consultation ____ At Request of Patient

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check one: ____ Yes ____ No Initial________________

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance o this authorization at any time I can revoke this authorization by submitting a notice in writing to ROLLA FAMILY CLINIC. Unless revoked, this authorization will expire on the following date______________________. Or 1 year from date of signature, unless otherwise specified.

Re-discloser

I understand the information disclosed by this authorization maybe subject to disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The Facility, its employees, officers and physicians are hereby released for any legal responsibility or liability for discloser of the above information in the extent indicated and authorized herein.

Signature of Patient or personal representative who may request Disclosure:

I authorize ROLLA FAMILY CLINIC to use and disclose the protected health specified above.

Signature Patient/Authority to Sign:______________________________ Date:__________

Witness:____________________________________ Date:__________________

LIST DOCTORS AND OFFICES YOU HAVE BEEN TO WITHIN THE LAST 2-3 YRS.:

Dr. Name:____
Office Name:____
Phone Number:____
Fax Number:____

Dr. Name:____
Office Name:____
Phone Number:____
Fax Number:____

Dr. Name:____
Office Name:____
Phone Number:____
Fax Number:____

Dr. Name:____
Office Name:____
Phone Number:____
Fax Number:____

Dr. Name:____
Office Name:____
Phone Number:____
Fax Number:____

I allow the facilities listed above to send any/all my records to **ROLLA FAMILY CLINIC**.

X____
Patient Name/Guardian