



RESDIENTIAL MEDICAL KARE, LLC

AUTHORIZATION FOR USE OR DISCLOSURE (RELEASE) OF/ REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Residential Medical Kare, LLC Name:	Patient Name (Printed):			Date of birth: <u>///</u>	
Vienna, VA 22182 Ph: 571-653-5273 (KARE) Fax: 703-665-4154 Information Requested: Entire Medical Record EKG Most recent Pathology Reports Consultation Reports History and Physical Progress Notes Last 2 Visits Immunizations Medication List Current Radiology Reports Discharge Summary Laboratory Reports Other: The patient or the patient's representative must read and agree to the following statements: I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my abilit to obtain treatment, receive payment, or eligibility for benefits unless allowed by law, including research-related treatment which may be conditioned upon this authorization. Residential Medical Kare, LLC may condition the provision of health care solely to create protected health information for disclosure to a third party upon my signature of this authorization. I understand that information released according to this authorization may lose th protections of federal privacy regulations due to re-disclosure by the recipient. Access to medical records may be subject to additional state and federal regulations. I understand that this disclosure may include information regarding drug and alcohol abuse, psychiatric and/or mental illness, accidents, disability, birth defects, cancer, ar genetic information. I understand that I may revoke this authorization at any time by notifying the providing organization in writing.	Organization receiving the	information:	Reque	st information from:	
Ph: 571-653-5273 (KARE) Fax: 703-665-4154	Residential Medical Kare, LLC		Name:	Name:	
Ph: 571-653-5273 (KARE) Fax: 703-665-4154	10214 Brittenford Drive		Address:		
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