RESDIENTIAL MEDICAL KARE, LLC

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

I authorize the use or disclosure of my individually identifiable health information as described below:

Patient Name (Printed): _____ Date of birth:___/___/_____

Organization receiving the information:

Residential Medical Kare, LLC

10214 Brittenford Drive

Vienna, VA 22182

Ph: 571-653-5273 (KARE)

Fax: 703-665-4154_____

Request information from:

Name: _____

Address: _____

_____

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 ability 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 the 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, and genetic information. I understand that I may revoke this authorization at any time by notifying the providing organization in writing.

Signed:_____**Dated:**_____

Name of representative:_____ **Relationship:** _____