RELEASE OF INFORMATION AUTHORIZATION

Med Eval, Corp.
9 Germay Dr.
Wilmington, DE19804
Phone: 302-594-0630
Fax: 302-689-1114

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Last 4 Digits SS#: _____

Records requested from Dr. _____

Doctors Phone Number: _____

Doctors Fax Number: _____

Information requested for continuum of care:

Diagnosis/Problem List
Progress Notes

Date of Service: Previous 12 months.

If last date of service is aged later than 12 months; please send 3 most recent progress notes.

I authorize release of the health information described above and understand that:

1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric conditions, unless restricted as follows:_____
2. Once information is disclosed pursuant to this Consent/Authorization, I understand that the federal privacy law (45 C.F.R. parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it.
3. I may revoke this Consent/Authorization at any time, except to the extent that action has been taken in reliance on it. To revoke it, I must provide the Privacy Officer - at the address listed at the bottom of this form - with a written revocation which will not be effective until received and approved by the Privacy Officer.
4. I may refuse to sign this Consent/Authorization and this refusal will not affect the care provided to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party.

Patient Signature: _____ **Date:** _____