James A. Rice D.O. LLC
P.O. Box 609
Mount Vernon, IN 47620
Phone: 812-838-3730
Fax: 812-833-0703

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing the authorization, I authorize (name of previous doctor or facility):

_____

_____

to disclose my protected health information to **Dr. James A. Rice D. O.**, at the above address.

The reason for this authorization is:

_____ Transfer of medical care _____ Entire Record

_____ Share medical information _____ Partial Record

_____ Other

Explain: _____

_____

This authorization releases **James A. Rice D.O. LLC** of any liability resulting from the release of my protected health information. This release will expire 90 days from the date signed.

Patient Name (Please Print): _____

Date of Birth: _____ SSN: _____-_____-_____

Patient Signature/Legal Guardian: _____ Date: _____/_____/_____

I understand that information to be release may include HIV infection and/or Alcohol/Drug information (please check one):

_____ Certify release _____ Do not certify release HIV/sexual records