OccMed South, LLC

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Donald W. Casey DO

Please send a copy of this release with requested records.

Patient Name	Date of Birth	Social Security Number
Address	City, State	Phone

RELEASE FROM	**RELEASE TO:**
Physician/Facility Name	Physician/Facility Name:
Address	Address
Phone Number Secure Fax Number	Phone Number Secure Fax Number

Reason for Release Please Circle

Follow Up Care Transfer of Care Moving Personal File Legal Consult Other:_____

PHI to be released

Recent H&P/Discharge Summary	Lab Reports	Last 3 Visits	X-ray report
Other			

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I also authorize the release of HIV/HTLV/AIDS test results.

Yes_____ No_____ Initials_____

This release is valid for 1 year from the date of the signature. Copy is valid as original. I understand that I may revoke this release at any time with a written request, but will not apply to records released prior to acceptance of revocation request.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42CFR Part 2 may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 14,] and the Privacy Act of 1974 [5 USC 552a]

Signature:	Date
Witness by:	Date