Rachel D. Maree, MD, MPH

RELEASE OF INFORMATION

Your signature below indicates that you have read the information about practice policies in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of patient Date

_____

Printed name of patient

Your signature below indicates receipt of a copy of the Health Insurance Portability and Accountability Act (HIPAA) notice and privacy practices.

_____ _____

Signature of patient Date

_____

Printed name of patient

Rachel D. Maree, MD, MPH

RELEASE OF INFORMATION

Legal Name:_____

Date of Birth: _____

Home Address_____

City_____State_____Zip_____

Phone:_____

E-mail: _____

Relationship Status: _____

Employer & Position: _____

Emergency contact and phone number: _____

Insurance (List company name, name of plan, member ID, Group Number): _____

_____

Pharmacy (name, address, phone number): _____

Medical History:

Medical conditions/surgeries/major illnesses:

_____

_____

_____

_____

Allergies (& reactions):

_____

_____

Current Medications (include supplements/vitamins/herbs/birth control):

_____

_____

_____

Psychiatric History

Diagnoses & past treatment (briefly):

_____

_____

_____

_____

_____

Medication trials:

_____

_____

_____

Rachel D. Maree, MD, MPH

RELEASE OF INFORMATION

Patient Name_____Date of Birth _____

This form authorizes Dr. Rachel D. Maree to release and exchange health information to/with the following providers/entities (please list name and phone/fax):

1. Primary Care Physician:

_____

_____

2. Additional Provider:

_____

_____

3. Other:

_____

_____

This information can include:

□ Copies of progress notes

□ List of medications and doses

□ Testing/lab results

□ Treatment plan and summary (written and verbal)

□ Other (Specify):

Please select one of the following:

□ This authorization shall remain in effect until the end of treatment.

OR

□ This authorization shall remain in effect until this specified date: _____

I understand that I may revoke this consent at any time by notifying this office in writing. Such revocation will not extend to release of information that has already occurred from this authorization.

_____ _____

Signature of patient or guardian Date

_____

Printed/Typed name of patient