Nemechek Consultative Medicine, Inc.
Patrick M Nemechek, D.O.
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Please Fax Records to 866-480-0357

RELEASE OF MEDICAL RECORDS

The undersigned hereby authorizes and requests:

Doctor Name: _____

Hospital Name: _____

Street Address: _____

City / State / Zip _____

To release the following information:

(X) Last 2 years of medical record info including but not limited to: H & P, notes, consultations and lab/testing results.

This information will be used for: (X) Consultation

I understand that my medical records may include HIV, psychiatric, alcohol or drug abuse information. This information may be protected by Federal and State Regulations. I also understand that I may revoke this consent at any time except to that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below.

SPECIFICATIONS OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES (if left blank this consent expires in 90 days).
EXCUTED THIS _____ DAY OF _____, _____.

_____ _____
(WITNESS) (Signature of Patient)

_____ _____
(WITNESS) (Signature of Patient, Guardian or Authorized Representative)

_____
(Nature of Relationship)

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL RREGULATIONS (42 CHR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD MY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSONS WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN $500 IN THE CASE OF A FIRST OFFENSE, AND NOT MORE THAN $5000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.

Drug Abuse Office and Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 USC 4582)

(Please return a copy of this consent with requested information)

RELEASE OF INFORMATION

Patients Name: _____

Date of Birth: _____

SS#: _____