



Authorization for Release of Medical Records

I, _____, authorize the following protected health information.

(Person Authorizing Release)

Released from the medical record of:

_____	_____	_____
Patient's Last Name	First Name	MI

Street Address		

_____	_____	_____
City	State	Zip

_____	_____	
Patient's Date of Birth	Social Security Number	

Medical Records Released From: Name of Physician: _____ Address: _____ City, State, Zip _____ Phone _____ Fax _____
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Medical Records Released To Riser Medical Associates 2274 Hwy 43 South Picayune, MS 39466 (601) 798-5798 Office (601) 798-1058 Fax (Circle one) James M. Riser, MD Clifford N. Lowe, MD Jimmy L. Kittrell, Jr., MD
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Reason for Release of information: _____

Please note specific dates or information to be obtained:

I understand that this authorization is valid for six months, unless I notify Riser Medical Associates otherwise. I may revoke this authorization in writing at any time except to the extent that Riser Medical Associates has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Riser Medical Associates to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. I understand that I may be billed per the fee schedule for copies of my medical records with the exception of records directly released from Evans Medical Group to another Professional Medical Facility. This information will be requested in a prompt manner according to the standards of Riser Medical Associates provided all information has been supplied correctly.

_____ SIGNATURE OF PATIENT	_____ Relationship	_____ DATE
_____ PARENT / LEGAL REPRESENTATIVE		

If completing on behalf of another adult, a signature is required from that individual. If you have Power of Attorney on behalf of another individual, please provide us with a copy of the legal document. POA copy attached. _____

Staff Only Date Released: _____ Released by: _____ Notes: _____
