Chase Brexton Health Care
Because everyone's health matters.

RELEASE OF INFORMATION (ROI) TO DISCUSS HEALTHCARE

Patient Information:

Legal Name: ______________________________ DOB: ________________

Name preference (How would you like to be addressed?): ____________________ Phone: ________________

I give permission for Chase Brexton to discuss my health as noted below with the following individual(s):

☐ Medical ☐ Dental ☐ Behavioral Health ☐ Substance Abuse

Name: ____________________ Phone Number: ________________ Relationship: ________________

Name: ____________________ Phone Number: ________________ Relationship: ________________

Name: ____________________ Phone Number: ________________ Relationship: ________________

Name: ____________________ Phone Number: ________________ Relationship: ________________

I understand that:

1. This HIPPA authorization for use and disclosure of information form is voluntary;
2. My treatment and the payment for my treatment will not be affected by my signing or not signing;
3. I may revoke this authorization at any time by notifying Chase Brexton in writing, but the revocation will not apply to information that has already been disclosed;
4. The information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected; and
5. I may request a copy of this authorization.

Signature of Patient or Patient's Legal Representative: ______________________________ Date: ______________

Printed Name of Legal Representative (if applicable): ____

OFFICE USE ONLY: This signed request or the above mentioned records were forwarded to the requested recipient via:

[ ] Mail [ ] Fax [ ] Handed to recipient [ ] No action needed

Employee Name: ______________________________ Date: ____________________