

# Ridge Family Practice, P.C.

• Clarine I. Coker, M.D. • Alan J. Pokorski, P.A. • Tammy L. Hunke, P.A.-C.

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**I hereby authorize Ridge Family Practice, P.C. to RELEASE the following information:**

(Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Complete Health Record | <input type="checkbox"/> Office Notes    | <input type="checkbox"/> Lab Reports     |
| <input type="checkbox"/> Radiology Reports      | <input type="checkbox"/> Billing Records | <input type="checkbox"/> Procedure Notes |
| <input type="checkbox"/> Other _____            |  |  |

### To Facility/Person:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

This information may be used/disclosed for the following purposes:

(Check all that apply)

- |   |                                      |                                    |
|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Patient Request      | <input type="checkbox"/> Legal       | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Health Care Transfer | <input type="checkbox"/> Other _____ |                                    |

**I hereby authorize the release of data and information relating to:**

(Check all that apply)

- |  |  |                                   |
|--|--|-----------------------------------|
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Mental Health | <input type="checkbox"/> HIV/AIDS |
|--|--|-----------------------------------|

This authorization will be valid for 180 days from the date it is signed or until \_\_\_\_\_. This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. Information used/disclosed pursuant to this authorization will be subject to re-disclosure by the recipient and no longer protected.

\_\_\_\_\_  
Signature of patient or Legal Guardian

\_\_\_\_\_  
Date

Relationship to patient: \_\_\_\_\_

201 Ridge St. #201  
Council Bluffs, IA 51503  
Phone: (712)322-5899  
Fax: (712)322-5730