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 *OBTAIN* the following information:
(Check all that apply)

- ☐ Complete Health Record
- ☐ Office Notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Billing Records
- ☐ Procedure Notes
- ☐ Other _____

From Facility/Person:

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Fax: _____ Phone: _____

This information may be used/disclosed for the following purposes:
(Check all that apply)

- ☐ Patient Request
- ☐ Legal
- ☐ Insurance
- ☐ Health Care Transfer
- ☐ Other _____

I hereby authorize the release of data and information relating to:
(Check all that apply)

- ☐ Chemical Dependency
- ☐ Mental Health
- ☐ 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: _____

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