RIO GRANDE MEDICINE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

JULIO A SAVINON MD **WILIAM H. TORKILDSEN MD** **MARI BLOOMQUIST FNP**

I authorize RIO GRANDE MEDICINE, to release any or all medical information about me including AIDS/IHIV test results and diagnosis; drug/alcohol abuse, and Psychiatric diagnosis and treatment record to my insurance company(s). Additionally, I authorize without further action by, on my behalf; said physician to disclose all or any part of my record to any person or corporation (including but not limited to: hospital or medical service companies, insurance companies, workers' compensation carriers, welfare agencies, and/or my employer) who is or may be liable under a contract to (1) any of the physician/providers listed above, (2)the patient, (3) a family member, or (4) the patient's employer, for all or a portion of the physician's fee for services rendered. This notice is in effect until further notice is provided by me.

I further authorize the above mentioned physicians to release my social security number *as* it pertains to the filing of insurance claims and the exchanging of authorized medical record information.

Patient Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

I request that authorized Medicare benefits, or other insurance benefits, be made on my behalf to any of the above named physicians/providers for medical services rendered. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine these benefits or benefits payable of related services.

Patient Signature: _____ Date: _____

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