Relievus™
Toll Free: (888) 985 - 2727 · Fax: (609) 567 - 8832

Authorization for Release of Information

Name of Patient: _____ **Date:** _____

Relievus is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity below that you approve to receive information.	**Description of Information to be Release** Check each item below that can be given to the person/entity as indicated on the left.
☐ **Voicemail**	☐ **Results of Lab tests/x-rays** ☐ **Other:** _____
☐ **Spouse (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____
☐ **Parent (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____
☐ **Other (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this arbitration may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Patient/Legal Representative Name	Patient/Legal Representative Signature	Date