

# **RAVINIA ASSOCIATES IN INTERNAL MEDICINE, LTD.**

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In an effort to prepare our records for our new Computerized Patient Record, we would like to update our information regarding your Medical History and Medication History.

Please fill out the attached forms and return them to the Front Desk prior to leaving the office. This information is confidential and will be put into the computer and available for your visit when we begin our computerized process.

We appreciate your patience as we prepare for our new computer system.

Thank you for your cooperation, and as always please let us know if you have any questions.

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## PERMISSION TO RELEASE MEDICAL RECORDS

Patient's Name \_\_\_\_\_  
(First) (Middle) (Last)

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Medical Record # \_\_\_\_\_

**PERMISSION IS HEREBY GRANTED FOR RELEASE OF MEDICAL INFORMATION TO BE FORWARDED TO RAVINIA ASSOCIATES.**

From: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The following information may be released

_____ Laboratory Data	_____ Progress / Doctors Notes	_____ All records
_____ Radiology Reports	_____ Medication Records	_____ Other _____
_____ Pathology Reports	_____ Immunization Records	_____

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)

**Required**

I do \_\_\_\_\_ do not \_\_\_\_\_ specifically consent to transmission of my medical records via fax machine.

\_\_\_\_\_  
(Signature) (Date)

**Optional**

I recognize that the information disclosed may contain drug / alcohol information that is protected by federal and state law. I specifically consent to disclosure of such information.

\_\_\_\_\_  
(Signature) (Date)

**Optional**

I recognize that the information disclosed may contain Mental health information that is protected by federal law. I specifically consent to disclosure of such information.

\_\_\_\_\_  
(Signature) (Date)

**Optional**

I recognize that the information disclosed may contain Information regarding sexually transmitted diseases or HIV / AIDS testing information. I specifically consent to disclosure of such information.

\_\_\_\_\_  
(Signature) (Date)

