



Dr. Elaina M. Groo
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Authorization For Use and Disclosure of Identifying Health Information

Patient Name: _____ Patient Date of Birth: _____
 Patient Address: _____ Patient Phone: _____

Records Release

I authorize the release of my health information from your office, to me or the office I list below. I realize that this information may include (if applicable) information about HIV infection or AIDS, information about substance abuse treatment, information about mental health services, and is released under the following conditions:

- 1] Last examination (including any and all supplemental testing) and all other records, specifically:

- 2] This information is to be given to or sent to: _____

- 3] The purpose for this release is at the request of the individual listed here: _____
- 4] Expiration Date of this Request: _____

The office of Dr. Elaina M. Groo is HIPPA compliant, and your protected under our office's HIPPA Office Policies and Guidelines. We are unable to assure HIPPA compliance of the office where records are requested to be sent.

I am signing this request for release of records voluntarily. I agree to the fee of \$0.75 per page for my records.

Patient's Signature: _____ Date: _____

If signing as a representative of the patient, list relationship and authority:
