# RENEW TOTAL BODY WELLNESS CENTER

## THOMAS W. ROHDE, M.D., FAAFP

**www.DrRohde.com**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**I,** ____________________________________ **Phone**: ______________________ **DOB**:____________
**Patient Name**

**Authorize:** ____________________________________ ____________________________________
**(Name of Institution/Healthcare Provider)** **Street Address**

________________________________________________________________________________
**City, State, Zip Code**

**to disclose to:** **Thomas W. Rohde, M.D., FAAFP**
**3798 E. Fulton Avenue**
**Decatur, IL 62521**

**information from my health record. I understand that the specific type of information to be disclosed includes: (please strike any non-desired disclosures) medical records, including alcohol abuse, drug abuse, mental illness, HIV/AIDS testing or other sensitive information and patient's record cards, x-rays, x-ray readings and reports, laboratory records and reports, all tests of any type and character and reports thereof, hospital records, reports, discharge summaries, correspondence, and any and all records pertaining to medical care, history, condition, treatment, diagnosis, prognosis or etiology:**

________________________________________________________________________________

________________________________________________________________________________

**and that this disclosure is made for the following purpose(s):**

________________________________________________________________________________

________________________________________________________________________________

____________________ ________________________________________________________
Date of Signature Signature of Patient or Person Authorized to Sign on Behalf of patient*

________________________________________________________
Relationship to Patient (if Applicable)

____________________ ________________________________________________________
Date of Signature Witness

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

*Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent; the spouse or personal representative of a deceased patient; or any person authorized in writing by the patient, which is witnessed and dated.