INVICTUS CLINIC

Medical Records Release Form

1. Authorization
I authorize Invictus Clinic, LLC to use and disclose the protected health information described below:
2. Effective Period
This authorization for release of information covers the period of healthcare from:
   a. all past, present, and future periods.
3. Extent of Authorization
   a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
4. This medical information may be used by the person/organization I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Please list below the following people you would like to authorize Invictus Clinic, LLC to use and disclose protected health information:

(Name) _____(Phone #) _____(Relationship)_____.

(Name) _____(Phone #) _____(Relationship)_____.

(Name) _____(Phone #) _____(Relationship)_____.

Signature of patient or personal representative Patient date of birth: _____

Printed name of patient or personal representative and his or her relationship to patient

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Date_____