



Physician's Verification of Relationship with Patient

Section A – Patient Information (individual whose information will be released):

Patient Name: (Last, First, Middle Initial, Title)

Date of Birth: MM/DD/YYYY

Section B – Authorized Person (person(s) or organization to receive patient's information)

(Please include the name, address, and phone number of the person(s), category of persons or organization to whom the patient's information will be sent)

Section C – Information to be Released: (type of information to be sent).

1. **Description of the Information to be Disclosed:** (Type of information that will be released. Please check only the types of information that apply to this request)

☐

X-ray Images

☐

Ultrasound Images

☐

Radiologist Report

☐

Medical Record

2. **Date(s) of Treatment and/or Service related to the Information to be Disclosed:** (Specify the date or range of dates that TridentCare provided treatment or service(s) to the patient related to the requested information).

From: ____ / ____ / ____ To: ____ / ____ / ____
MM DD YYYY MM DD YYYY

SECTION F –Patient or Representative's Signature: (please sign and date this certification)

I, the undersigned, certify that the above-named patient is under my care and the records being requested are pertinent to treatment and coordination of care for another HIPAA compliant purpose. Additionally, if required by applicable state or federal law, the patient and/or responsible party have provided consent to the release of information for continued treatment or other HIPAA compliant purpose.

Signature of Patient or Representative:

Date: (MM/DD/YYYY)

Physician or Organization Printed Name and Address: