# 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 Films ___ Ultrasound Films ___ Lab Results ___ 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 D –Treating Physician'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 or 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 Physician:** | **Date:** (MM/DD/YYYY) |
|---|---|

**Physician or Organization Printed Name and Address:**