



Release of Medical Information

for patients of

River Mill Osteopathic

157 Silver St.
Waterville, ME 04901

Phone/Text 207.705.0700

Fax 207.466.8454

rivermillosteopathic@gmail.com

Patient Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Please judiciously select only records from the listed facility that are relevant to your ongoing care.

Facility to provide records _____

Please include the following Protected Health Information in the requested disclosure and release:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Consult Notes | |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Stress Testing | <input type="checkbox"/> Speech Therapy | |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Cardiac Monitoring | <input type="checkbox"/> Physical Therapy | |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> EKG | <input type="checkbox"/> Echo | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Sleep Study | <input type="checkbox"/> EEG | <input type="checkbox"/> EMG | <input type="checkbox"/> Vaccination Records |
| <input type="checkbox"/> Pulmonary Function | <input type="checkbox"/> Emergency Room Visits | <input type="checkbox"/> Growth Charts | |
| <input type="checkbox"/> Swallow Evaluation | <input type="checkbox"/> Hospital History & Physical | <input type="checkbox"/> Urgent Care Notes | |
| <input type="checkbox"/> Cognitive Testing | <input type="checkbox"/> Hospital Progress Notes | <input type="checkbox"/> Clinic Notes | |
| <input type="checkbox"/> Neuropsych Evaluation | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Counseling Notes | |

Other _____

Exclusions _____

The following categories of information carry special protections and are to be released only if checked

- Substance Use Disorder HIV / STI Reproductive Care Genetic Testing

I do hereby consent and authorize the release of copies of my medical records as above to River Mill Osteopathic:

Signature _____

Printed Name _____ Date _____