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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ______________________________ ____________________
Patient Name Date of Birth

I hereby authorize and give my consent to release my medical information

FROM ____________________ TO ____________________
____________________ ____________________
____________________ ____________________
Phone ____________________ Phone ____________________
Fax ____________________ Fax ____________________

In regard to medical services rendered to me and may be limited to the following specific items: (Please check only one)

( ) Most recent notes, labs, reports (2-3 years)
( ) The following dates only: ______________ to ______________
( ) Other: ______________________________

____________________ ______________________________
Date of Consent Signature of Patient, Parent, or Authorized Representative

If signed by person other than patient, state relationship to patient: ______________
If signed by authorized representative, state why patient is unable to sign______________

Records will be faxed unless otherwise noted here to be picked up ______________
Phone number to call if records are to be picked up when ready______________

There is normally a fee to copy or transfer records depending on the quantity. You will be notified of that fee prior to sending records.