Authorization to Release Medical Information

_____

(Health Care Provider)

Phone_____ Fax_____

Is herby authorized to release medical information on

_____

(Patient Name)

Date of Birth_____

Medical information requested:

__All Medical Records
__Allergies
__Discharge summaries
__History and physicals
__X-Ray films
__Laboratory data
__Medications
__Operative findings
__X-Ray reports
__Other_____

In accordance with HIPAA laws this release is in effect for one year after today, or when patient revokes release.

To provide the best possible medical care to the patient, the information is requested by

Meridian Family Medicine
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CONSENT: I hereby consent to the release of medical information as stated above.

_____ _____
Signature of Patient Date

_____ _____
Signature of authorized agent Relationship of agent

Medical records are confidential and re-disclosure is prohibited.