AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize you to release the following information from the medical record of:

Name of Patient: _____

Address: _____

City, State, Zip Code: _____

Date of Birth: _____

Date of Service: _____

To (Name): _____ From (Name): _____

To (Address): _____ From (Address): _____

To (city, state, zip): _____ From (city, state, zip): _____

☐ Discharge Summary ☐ Lab Reports

☐ History & Physical ☐ EKG ☐ EEG

☐ Operative & Pathology Reports ☐ Radiology Reports

☐ HIV related records ☐ Other:

Purpose of Disclosure: _____

It is further understood that the information released is for the specific purpose above and may not be provided in whole or in part to any other agency, organization, or person.

This consent will expire 12 months after date of signature.

Signature of Patient or Person Legally Responsible for Patient: _____ Date: _____

Relationship to Patient: _____