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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____
Address: _____
Phone Number: _____
SSN: _____ Date of Birth: _____

INFORMATION TO BE RELEASE TO:

Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

INFORMATION TO BE RELEASE FROM:

Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

For the purpose of (e.g. leaving this practice to seek care with another physician, consultation with a physician of another specialty, legal or insurance purposes):

_____

Information to be released is to include (please check to indicate):

__Problem List
__ Medication List
__ Laboratory Results
__ Imaging reports/X-rays
__Vaccination Record
__ Discharge Summaries
__ Consultation Reports
__ Entire Record (Transferring Care)
__G.I. Medical Records Only
__ Other: _____

I understand that if this request for release if information is for the purpose of leaving this practice to seek care with another physician I must pay any remaining balance on my account before records can be released.

Medical records released to parents/patients will be charged a fee of: $1.00 for the first 25 pages and 50 cents for each additional page. Cost of postage will be added if mailed. Payment will be required before records are released

Signature: _____ Date: _____
Relationship to Patient: _____ Expiration Date: _____

Expiration date will be one year from date of signature if this is left blank