

GoPrivateMD

Authorization to Release Medical Records

Name of Patient _____

Date of Birth _____

I authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED: History & Physical, Consultation Report, Emergency Room Record, Operative Reports, Discharge/Death Summary, Face Sheet
Lab/Path Reports, X-Ray Reports/Images, ECG Copy/Report

FROM:

TO:

GoPrivateMD, LLC
Thomas A. Pascuzzi, MD
8208 Louisiana Blvd NE, Suite B
Albuquerque, NM 87113

Fax: 505-508-5249

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____ Signature: _____

Patient or Representative

Print Name of Legally Authorized Representative