MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I AUTHORIZE _____
to disclose the following protected health information about me to:

_____
Name of physician, practice, facility, or person(s) where records will be sent.

Please forward a copy of the following medical records:

❒ COMPLETE MEDICAL RECORDS ❒CONSULTATION REPORTS ❒MEDICATIONS/ALLERGIES

❒ BIOPSY REPORTS ❒LAB REPORTS ❒SURGICAL PROCEDURES

For the following dates of service: _____to _____

SELECT ONE DELIVERY METHOD

❒ **MAIL**

_____
Mailing address

_____
City/ State/ Zip

❒ **FAX**

_____
Fax Number

_____ _____ _____
Patient/Parent/Legal Guardian Signature ***Relationship*** ***Date***

This Permission Expires on _____
Expiration Date

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