



RECORDS RELEASE AUTHORIZATION

Patient Name _____ Patient Address _____
Date of Birth _____
Telephone # _____

I authorize _____ to () Send my records to:
() Obtain my records from:

Name of Facility or Physician

Street Address

Telephone and Fax #

The type of information to be used or disclosed is as follows:

- () Consult Notes () Lab Results () X-Ray Reports () Pathology Reports
() Operative Reports () Complete Medical Record

From (Date) _____ To (Date) _____

For the purpose(s) of:

- () Continuing Care () Insurance Claims () Litigation () Other

I authorize the use and disclosure of my health information as described above, including written and verbal exchanges about the information unless I indicated otherwise. I understand that the above records may contain information regarding STD's, HIV/AIDS, mental health, substance abuse, or other sensitive information. A copy of this form is as effective as the original.

This authorization will expire one year from the date of signing.
I have reviewed and I understand this authorization.

Signature of Patient/
Legal Representative

Relationship to Patient

Date