AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

DATE:

Information Requested From:
_____
_____

Patient Name _____
Date of Birth _____
Account # _____

Information Requested
_____
_____

Reason For Requesting Information
_____
_____

Information to be Sent To:
_____

Telephone:
Fax:

I understand that I am giving my permission to the above named physician for disclosure of my confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

Name _____

Signature _____

Witness _____

Date _____

Records copied by _____
Mailed: _____