



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

PLEASE READ THE FORM CAREFULLY AND FILL OUT COMPLETELY

1. I AUTHORIZE:

2. TO RELEASE TO:

\_\_\_\_\_  
Name of sending person/organization

\_\_\_\_\_  
Name of receiving person/organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
City State Zip Code

3. INFORMATION TO BE RELEASED: (Check all applicable)

Fax # \_\_\_\_\_

- All Progress Notes
- Lab Reports
- X-Ray Reports
- Other

4. RECORDS FROM THE TIME PERIOD: \_\_\_\_\_

to \_\_\_\_\_

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

- Continued Medical Care
- Payment of Insurance Claim
- Legal
- Other

6. I understand that this authorization shall be valid for 90 Days. I understand that I may revoke this consent form at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requester may be provided with a copy of this authorization.

\_\_\_\_\_  
Patient's Name (at time of treatment)

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

**ALLOW 7 -14 BUSINESS DAYS TO PROCESS REQUEST**