AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient's name ____

Date of birth ____/____/____ ss # ______-___-_______

Telephone number (____) ____-_______

Release Medical Records From:

Name of provider ____

Address ____
City/ST/Zip____
Phone #____

Disclose Medical Records To:

Name/Facility ____

Address ____
City/ST/Zip____
Phone #____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

FEES: I understand and agree that there may be costs associated with this request in compliance with State and Federal Copying laws.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_______________________________________ Date: ______________________________
Patient/Guardian/Representative Signature

_______________________________________ Date: ______________________________
Witness Signature