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## **Authorization for Release of Medical Records**

Patient Full Name		Birth Date (Mo/Day/Year)
Street Address		Phone (Cell)
City, State, Zip Code		Phone (Other)
Release Information From:		Release Information To:
Name of Facility, Person, Company		Name of Facility, Person, Company
Street Address, City, Zip		Street Address, City, Zip
Phone		Phone
Dates of Information to be Dis	closed: From	to (or) All
Type of Information to be Disc	closed (circle all th	nat apply):
History & Physical	Pathology Reports	
Vaccine Records	Laboratory Reports	
Progress Notes	Radiology Reports	- ,
		nation related to AIDS (Acquired Immunodeficiency ection, psychiatric care and/or psychological assessment
Purpose of Disclosure (circle on	e)	
•		ersonal/Moving Change of Doctor
Format (only select one)	Delivery Metho	d: (only select one)
Paper (or) CD (or) Fax	Regular U.S. Mail	(or) Pick-Up (or) Fax to
12 months from the date of signature that it will not affect any information information used or disclosed may be sit, and would then no longer be protected.	<ul> <li>I understand that on released prior to subject to re-disclosu ted by federal regula</li> </ul>	the above named patient. This authorization is valid for I may cancel this request with written notification but o notification of cancellation. I understand that the are by the person or class of persons or facility receiving ations. I understand that the medical provider to whom ment of me on whether or not I sign the authorization.
Signature of Individual or Guardian or P	ersonal Representat	ive of Patient's Estate
Print Name of Individual or Guardian or	Personal Represent	ative Date