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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date _____ Patient Name_____

Date of Birth _____ Phone Number_____

From: Current Physician_____

Phone Number _____ Fax Number _____

I authorize the release of the following information:

_____ Complete Record

_____ Specific Dates of Records From_____ to _____ Only

_____ Pathology Reports Only

_____ Other – Records of Care Concerning the Following Condition(s)_____

_____

This information will be used to further assist in my medical care and should be sent to:

New Physician Name _____

Address _____

_____

Phone Number _____ Fax Number _____

I authorize and request that any and all Medical Information, as indicated above, be released according to the terms outlined in this agreement.

Signature of Patient or Guardian _____Date_____

Print Name/Relationship to Patient _____

Witness Signature _____