REGIONAL
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IMMUNOLOGY CENTER

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Medical Records Release

Pt Name: _____ Chart: _____

DOB: _____ Phone #: _____

I hereby authorize _____ to release medical information to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

_____ _____

Signature of Patient/Representative Witness Signature

Date: _____