Bonnie S. Friehling, M.D.
1511 Chapel Hill Road, Unit 5
Columbia, MO 65203
573-446-1200
fax 866-384-6483

Authorization for Release of Medical Information

Date: _____

Patient_____ Date of Birth: _____

I hearby authorize and request that_____
Address: _____
_____
Phone: _____ Fax:_____

furnish to Bonnie S. Friehling, M.D., all records, facts and particulars concerning my case history and the treatments and examinations received by me while under the care of above institution and/or practitioner for the following date:

_____ALL records
_____Records pertaining to dates from_____to_____

I hereby release_____and employees from any and all liability, claims or causes of action for providing the above information by my request including records in reference to treatment, hospitalization, outpatient care including psychological, psychiatric, drug abuse or addictiion, alcoholism treatment, sickle cell anemia, acquired immumodeficiency or test for human immunodeficiency virus. This authorization expires in 6 months unless sooner revoked by me in writing. This authorization is valid for release of information about treatment received by me prior to the signing of this form.

Patient signature: _____ Date:_____
Witness:_____ Date:_____