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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Patient's Date of Birth:

Patient's Address: Patient's Phone:

Requesting Records Be sent to:

Phone Number of office to be sent to:

Fax Number of office to be sent to:

The Information being requested is as follows: ___Complete Records ___ Labs ___ Imaging/Radiology
___ ER reports ___ Operative Notes ___ Hospital Reports
___ Pathology ___ History&Physical ___ Other

Transfer of care?

○ Yes ○ No

Patient Signature: _____ Date:_____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED.

If being requested to be sent to another office there is no charge. If you are a Patient requesting your records for yourself, please note that there is a $15.00 Fee.

By signing this form, I authorize you to release my confidential health information about me to the Physician/facility listed. One Physician/Facility per request.