



There is a 10 day processing time on all requests for records

Authorization for Release of Information

Patient Name _____

DOB

SS # _____

I Authorize:

Facility/Dr. _____

Address _____

Phone # _____

Fax # _____

To Release To:

Name _____

Address _____

Phone # _____

Fax # _____

Records for the period From _____ To _____

Reason for Request:

_____ Continued Treatment

_____ Attorney

_____ Insurance

_____ Other - Please explain _____

_____ Travel-OB patients

_____ Transferring Care to another Physician

There will be a copy charge for transfers.

I would like to have my records: _____ Mailed _____ Picked Up
_____ Faxed

I understand this authorization includes the release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal disease and any other statutory protected diseases. This authorization and consent will expire **thirty (30) days** following the date signed.

I understand that I may revoke this authorization and consent at any time, except to the extent that action has previously been taken.

Signature of Patient

Date

Signature of Parent/Guardian

Date

Confidentiality Notice

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