Authorization for Release of Medical Records

Patient Information

_____

_____

_____

_____

Date of Birth : _____

Social Security # : _____

Request Release from:

_____

_____

_____

_____

_____

_____

I hereby authorize you to release to _____ a copy
my medical records to be used for continuing medical care. I reserve
e right to revoke this authorization in writing at any time. Further, I
derstand that this Protected Health Information may be re-disclosed by
e recipient and thus, no longer protected under privacy rules.

_____ _____

tient or Guarantor Signature Date

Please include the FOLLOWING ITEMS:

_____Admission notes

_____Discharge summary

_____Operative reports

_____EKG'S

_____X-ray reports

_____Progress notes

_____Pathology reports

_____Consultations notes

_____Laboratory tests

_____Stress tests

_____Other_____

arks : _____

s authorization will expire on _____.