Authorization For Disclosure of Health Information

This form authorizes release of medical records to:

Physician Name: _____
Address: _____
City/State/Zip_____
Phone Number_____
Fax Number_____

From the records of:

_____ _____
Name of Patient Date of Birth

Please send the following information:

Check all that apply:
_____All medical records
_____Operative Reports, applicable dates _____
_____Lab Reports, applicable dates_____
_____Pathology Reports, applicable dates_____
_____Other (specify) _____

X_____ X_____
Provider Signature Date

The information contained herein is confidential and is being provided in response to a written authorization.

X_____ X_____
Signature of Patient or Legal Guardian Date