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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

You may refuse to sign this consent. This consent may be revoked at any time upon written notice, except to the extent that any person or organization has already taken action in release thereon. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected.

Patient name ____Date of birth____________

I hereby authorize the release/disclosure of patient's health care information FROM the following:

____
Person or organization to receive information

____
Street address

____
City State Zip code

I hereby authorize the release/disclosure of patient's health care information TO the following:

____
Person or organization to receive information

____
Street address

____
City State Zip code

This authorization applies to the following information:
_____ All records _______ Labs ______ Imaging reports ______ Immunization records

_____ Other:____

This information will be used for the following purpose:_________________________

____

This consent expires: ________ 30 days _____________________Other specified

Signature:_________________________________ **Date:**___________________________

Relationship to patient:____
If personal representative, attach copy of letter of administration.

For Office Use Only: Date of disclosure: _________________ **By:**__________________