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1098 Alder Ave
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned authorize _____ to release information
(name of previous location / physician)

from the medical records of _____ to be released to the office
(name of patient)

of _____.
(location / physician to be sent to)

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time.

REASON FOR REQUEST: □ Personal □ Transfer of Care □ Disability □ Insurance □ Legal Review □ Other (please explain): _____

TYPE OF MEDICAL INFORMATION REQUESTED: _____

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian /relationship to patient Date

_____
Patient Date of Birth