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RELEASE OF MEDICAL INFORMATION

PLEASE PRINT ALL INFORMATION
(You may fill out this form online and bring a printout to our office)

NAME: _____ BIRTH DATE: _____

FORMER NAME: _____ TREATMENT DATE: _____

I AUTHORIZE: _____

_____

TO RELEASE TO: _____

_____

INFORMATION REQUESTED TO BE RELEASED:

- ☐ PROGRESS NOTES
- ☐ LABORATORY NOTES
- ☐ X-RAY REPORTS
- ☐ OPERATIVE REPORTS
- ☐ PATHOLOGICAL REPORTS
- ☐ CURRENT PREGNANCY
- ☐ **ALL MEDICAL RECORDS**

This consent for release of confidential information expires in **ONE YEAR**. I understand I may review my medical records upon request. I understand I may revoke this authorization at any time, except to the extent that action has already been taken in compliance with the consent. This facility, its employees and the attending physician are hereby released from legal responsibility or liability for the release of the above information. I understand that the first copy of my records for the purpose of continuing care/or transfer of care is given free of charge. For any additional copies there will be a charge of $50.00.

SIGNATURE: _____ DATE: _____