Authorization for Release of Medical Records

PRINT PATIENT'S FULL NAME	DOB (Mo/Day/Yr)	PHONE

Street Address City, State, Zip Code

Requested Records:

□ All medical information □ Lab results □ Progress notes □ X-ray / CT / Ultrasound
□ OB care □ Operative & Pathology reports □ Other _____

PLEASE ONLY SEND THE MOST RECENT VISIT NOTES, SURGERIES & LABS.

Send Records To:

MD / Practice Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Copy Records From:

MD / Practice Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Purpose of Disclosure:

□ Referral to Specialist □ Insurance □ Transfer of care □ Legal Investigation
□ Disability Determination □ Second Opinion □ Coordination of care □ Other _____

I UNDERSTAND AND ACKNOWLEDGE THAT THE RECORDS MAY INCLUDE ALCOHOL/DRUG, MENTAL HEALTH, OR HIV/AIDS INFORMATION.

I understand that I may revoke this authorization at any time, in writing, and that such revocation will not affect information that has already been released.
Unless otherwise noted, this authorization will expire six months from the date on which it was signed.

Date: _____ Signature: _____

Date: _____ Witness: _____

Processing this request will require a minimum of 7-10 business days.

Date Completed: _____ Signature: _____

Faxed: _____ Mailed: _____ Picked up: _____

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Phone: 910-452-3666 Fax: 910-397-0930