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MEDICAL RECORDS RELEASE

Name:_____

SSN:_____

DOB:_____

I authorize Dr _____to:☐Obtain records from ☐Send / Release records to

NAME OF HOSPITAL/ DOCTOR/SELF_____

CITY_____ STATE_____ ZIP_____

PHONE_____ FAX_____

_____ Continued Medical Care _____New Patient

Most recent records needed: Office Visit EKG Operative Report

Stress Test X-ray Report Echo Report Other:_____

*(Give 3-5 days for Medical Release)

I understand that my records may contain information about alchol and/or drug treatment, mental health or psychiatric treatment, and /or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above, I also understand that this consent will expire six(6) months after the date below, or when the information requested has been received / released. A photocopy of this release shall have the same effect as the original.

_____ _____

Patient Signature/ Legal Representative (Relationship) Date

Office use only: Mailed_____ Faxed_____ Pick up in person_____