Authorization for Release of Information

Patient Information:

Name: _________________________________ Date of Birth:______________

Address:________________________________ Phone: ___________________

____

Release Medical Records FROM:

Health Practitioner Name: ____

Address:____

Phone:__________________________________ Fax: _______________________

Release Medical Records TO:

Health Practitioner Name: ____

Address:____

Phone:_________________________________ Fax: ________________________

Duration: This authorization shall become effective immediately and shall remain in effect until 1 year from the date of signature**.** **Revocation**: Authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Check the information to be released

___ General medical records from the last year ___ Recent blood work

___ Diagnostic test results:____

___ Other:____

Signature of Patient or legal Representative:________________________________ Date:____________