ONE GREAT PLACE TO GET WELL

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Records Request Authorization

PATIENT INFORMATION

Patient Name _____

Patient Date of Birth _____ Social Security Number _____

CONSENT FOR RELEASE OF INFORMATION

I, _____ authorize _____
(Name and/or facility)

_____
(Address, City, State, Zip) (Phone and Fax Number)

to disclose the following healthcare information for treatment on these dates _____.

The information released will be used for the following purpose:

_____.

I specifically authorize the following for release: ◯ Entire record

◯ Only those items listed below:

☐ Visit/Progress Notes ☐ X-ray / MRI Reports ☐ X-ray Films
☐ Range of Motion ☐ Lab Results ☐ Other _____

I authorize disclosure of the above mentioned medical records for the purposes stated above. I also am aware that I am not giving permission for any disclosure other that what is described above. I understand that I can revoke this authorization at any time, except to the extent actions have already taken place.

This release is effective for 180 days from the date signed unless other specifications follow:

_____

I understand that the parties in receipt of my healthcare information may not further disclose my information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date

Office Use Only_____
Date: Fax #: Pgs Copied Confirmation Received _____ Initials: