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Authorization for Release of Information

By completing this document, you hereby authorize the use or disclosure of your individually identifiable health information, as described below. In executing this authorization, you acknowledge that you do so voluntarily. Unless otherwise stated in our Privacy Notice, you have the right to revoke this authorization at any time.

Patient Name: ______________________________

DOB: ____________________ **SS#:** ____________________

Mailing Address: ____________________ **City/State/Zip:** ____________________

Home Phone: ____________________ **Cell Phone:** ____________________

Requesting Records From : ______________________________

Phone# : ____________________ **Fax# :** ____________________

Send Records To : ______________________________

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Change of Doctor: ______________ **Specialist:** ______________ **Other:** ______________

For patients transferring records out, there is a $25.00 charge for printed copies of record.

Authorization Signature: ______________________________ **Date:** ______________

I understand that the records and information to be released may contain and include information of a personal and confidential nature. This authorization is subject to revocation at any time by notifying this office in writing. Without revocation, authorization will automatically expire in 90 days from the date thereof.

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