

## AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I \_\_\_\_\_, date of birth \_\_\_\_\_ hereby  
request my medical records be released to:

\_\_\_\_\_  
Name or person or organization to receive records

\_\_\_\_\_  
Address/City/State/Zip Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### This authorization applies to all of the reports checked:

Medical History	Operative Reports
Lab/Path Reports	Health Assessment Questionnaires
Clinical Office Notes	Photographs

### Purpose of disclosure: (check all that apply)

Medical Care	Attorney
Insurance	Other _____

This authorization is valid for 90 days from the date of signature.

### Prohibition of Redisclosure

Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

\_\_\_\_\_  
Signature Date  
*The patient may revoke this authorization in writing at any time*

\_\_\_\_\_  
Patient's Printed Name Identification Number

\_\_\_\_\_  
Signature of Witness (optional)

**Note:** Fee of \$25.00 may apply

Return Completed Form To: Medical Records Dept. Fax 713/807-0630