DR. DONALD S. FULTON
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PERMISSION TO RELEASE RECORDS

PATIENT: _____ DOB:_____ DATE: _____

I GRANT PERMISSION FOR DR. DONALD S. FULTON'S OFFICE TO RELEASE MY RECORDS TO: _____.

IF RELEASING TO ANOTHER PRACTICE, THEIR CONTACT INFO:

PHONE: _____

FAX: _____

THE MEDICAL FINDINGS AND TREATMENTS DISCLOSED SHOULD COVER THE PERIOD OF:

- ☐ MOST RECENT
- ☐ 2-3 MOST RECENT
- ☐ FULL RECORD (PER STATE RECORD RETENTION LAWS)

BY INITIATING THIS REQUEST, I HEREBY RELEASE MY PRACTITIONER FROM ANY LAWS GOVERNING THE DISCLOSURE OF PROTECTED HEALTH INFORMATION. THIS PERMISSION WILL EXPIRE IN ONE YEAR OR WHEN I CHOOSE TO REVOKE IT, WHICHEVER COMES FIRST.

_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE