



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 : _____

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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