AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (Please Print): ____

Date of Birth: ________________________ Social Security #: _________________________________

I hereby authorize and request ____to release to

____

the following information from the medical records of the above mentioned patient from

(Date) ____________________to (Date) _______________________:

□ Complete Medical Record □ Physician's Orders □ Physician's Progress Notes

□ Discharge Summary □ History & Physical Exam □ Consultation Reports

□ OP and Path Reports □ Laboratory Tests □ X-Ray Reports

□ Doppler/EKG/Cath □ MRI/CT Scans □ PT/OT/ST

□Other: ____

Purpose: ____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for 180 days from the date signed.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

A photo static copy and/or faxed copy of this consent shall have the same legal effect as the original. I understand that the records disclosed may be released via fax machine.

____

Patient or Legal Representative Relationship to Patient Date

____

Witness Date