AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

MISSING INFORMATION MAY DELAY OR VOID THE RELEASE OF RECORDS.

PATIENT NAME_____ **DATE**_____

SS#_____ **D.O.B.** _____

I hereby authorize the release of my medical records to:	**RELEASE all records initialed:**	**INITIAL**
_____	ALL MEDICAL RECORDS	_____
_____	FINANCIAL RECORDS	_____
_____	ALL DATES	_____
	From: _____ To:_____	_____

This authorization shall be effective until (check one):

____ Past, present and future

____ Date or event: _____, unless I revoke it.

PATIENT'S SIGNATURE _____

AUTHORIZED REPRESENTATIVE:_____

Relationship to patient if patient is a minor (under 18) _____

THIS AUTHORIZATION MAY BE REVOKED BY THE PATIENT AT ANY TIME.

I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and the information may no longer be protected by federal confidentiality rules.