

# Authorization for Release of Medical Information

## Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

## Type of Information Requested:

- Office Visit Notes       Pathology Reports  
 Lab reports / Blood Tests  
 Other \_\_\_\_\_

## Information to be released from:

Physician & Clinic Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_

## Information to be received by:

Physician & Clinic Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_

## Information to be released for the following reason:

- Personal Record     Transfer of Care     Consult  
 Copy for my Primary Care Doctor     Insurance Claim  
 Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_