

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Pa e Na e: \_\_\_\_\_ Da e f B : \_\_\_\_\_

ID#: \_\_\_\_\_ Tee e: \_\_\_\_\_

Add e : \_\_\_\_\_

Release From: (Name of Facility of Clinician Releasing Information):

I a e e e a e f e d c a e c d f :

Fac /Na e f P c a : \_\_\_\_\_ Sa Pe e U e \_\_\_\_\_ O e \_\_\_\_\_

(S e c f ) \_\_\_\_\_

Add e (If d f f e e f Sa Pe e U e  
fac ): \_\_\_\_\_

Release To (Name of Facility/Clinician/Person Receiving Information):

Na e: \_\_\_\_\_

C e e Add e : \_\_\_\_\_

Tee e # \_\_\_\_\_ Fa # \_\_\_\_\_

Release Information:

Rea : \_\_\_\_\_ M f a e a \_\_\_\_\_ Re e e f c \_\_\_\_\_ Pe a f e

Please Release the Following (check all that apply):

\_\_\_\_\_ I a

\_\_\_\_\_ Lab a Re O ( e c f ) \_\_\_\_\_

\_\_\_\_\_ O e I f a ( e c f ) \_\_\_\_\_

Consent:

T f a e d e d b e a b e a e d e c e . I a e a e c e e a c  
f a a . I a e e a a a a e .

S a e f Pa e : \_\_\_\_\_ Da e: \_\_\_\_\_

W e e d B : \_\_\_\_\_ Da e: \_\_\_\_\_