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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of my medical records:

From: _____ To: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Records Requested: _____

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this authorization remains valid for one year. This authorization may be revoked at any time. The revocations must be in writing, signed by the patient or patient representative, and delivered to our office.

SIGNATURE:

I understand that the release of information is voluntary. I am confirming my authorization that the health care provider may use and/or exchange with the persons and organizations named above, the protected health information designated on this form. A photocopy or fax of this signed authorization is as valid as the original and should be sufficient for the same purpose.

Print Name

Signature

Date