AUTHORIZATION FOR USE OR DISCLOSURE
OF
MEDICAL INFORMATION

Patient Name: _____ **D.O.B.** _____

Address: _____

Phone#: _____ **SS#** _____-____-_____

I, _____, hereby authorize:

Facility Name/Provider: _____
Address: _____
City: _____
Phone:_____ Fax:_____

to release medical records and information pertaining to my medical history to:

Please send the following information: (Check 1)

__All Records
__History & Physical
__Consultations
__Allergy tests, Inj., & Antigen Record
__Insurance Information
__X-Ray & Lab Reports
__Progress Notes
__Diagnostic tests
__Other(specify):_____

I hereby authorize the releasing facility to release information as indicated. The releasing faciltiy is hereby released from all legal liability that may arise from the release of information requested. I understand that my medical records are protected and cannot be disclosed without my written permission. I also understand that my consent for release is subject ot my written revocation. This consent will remain in force from the date signed.

Date:_____ Signature:_____

Date:_____Witness to Signature:_____