Partners In Healthcare Naturally
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AUTHORIZATION FOR RELEASE OF RECORDS

IF MORE THAN 5 PAGES PLEASE MAIL UNLESS OTHERWISE REQUESTED

I,_____Birthdate:_____

Address:_____Phone:_____

Authorize:_____
Address:_____
Phone/Fax:_____

I authorize release of my medical records including confidential and/or communicable disease-related information, including HIV/AIDS information.

Please release the following information:

____All Medical Records
____Labs Only All or provide date of service_____
____Send only:_____

Release to:_____
Address:_____
Phone/Fax:_____

If you are requesting your records to be released to yourself or another physician, are you dissatisfied with our office for any reason?_____
_____

Patient Signature:_____Date:_____

Effective Date:_____Expiration Date:_____

Completed By:_____Date:_____

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