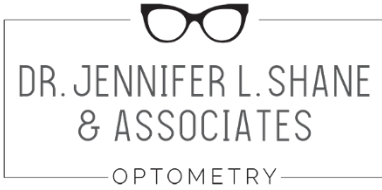

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—AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS—

To:		☐	This patient has come to our office for care. Please supply any necessary information and/or a copy of the patient's records for our use.
Address:			
City/State/Zip:		☐	This patient is being transferred to you for your care. If further information is required, please contact our office.
Tel:			
Fax:			

I authorize the doctor to release any medical information including diagnosis, test results, reports, and records pertaining to any treatment or examination rendered. I understand that this medical information will only be used for the following purposes: diagnostic, referring physician, or insurance. I further understand that any person or persons that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization signed by me for release of the information.

Patient (print name):		Patient DOB:	
Guardian (print name):			

Patient signature (parent or guardian if under age 18)	Date