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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Address: _____ Telephone#_____

I, the undersigned, hereby authorize _____ to release records to:

Name: _____

Address: _____

Phone: _____ Fax: _____

To release the medical information described below (please check all that may be released):

____Progress Notes *____Lab Reports* *____Operative Report(s)*

____Special Studies (EMG, MRI, Etc.) *____Other_____ (Please Specify)*

For the purpose of (please check the appropriate)

____Continuity of Medical Care *____Legal* *____Insurance*

____Other (please specify) _____

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

Patient's Signature_____ Date_____