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Release of Patient Record Information

This form must be completed in full.

Name of Patient: ____

Address of Patient: ____
Number & Street State Zip

Social Security # : ____________________ Date of Birth: ________________
Month Day Year

I hereby authorize ____
Name of Doctor or facility **releasing** information **Address** **Phone Number**

To release to: ____
Name of Doctor or facility to **Receive** information

The following information: ____

____

Covering the period of care from ______________ to ______________________

I understand that this information will be used for: ___________________________

____

I further understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

The doctor or facility releasing authorized information is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

______________________ ____________________________
Date **Signature of Patient**

If the patient is a minor or is unable to give permission to sign the foregoing because of physical disability or mental incompetence, complete the following: The patient is unable to sign the foregoing because: ____

____

Signature of Patient's Representative: ___________________________________

Relationship to Patient: ____

A charge may be added to transfer expired x-rays.

Form faxed/ mailed date ________ Office called for follow-up date__________