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Authorization to Release Medical Records

Physician or Facility to Release Records (From) _____

Patient Name _____

Date of Birth _____ Last 4 of SSN# _____

Information Requested:

Procedure Reports Entire Chart
 Pathology Reports Other _____
 Lab/Blood work
 Radiology

Release Records (to):

Name _____ Phone _____

Address _____ Fax _____

By signing this form, I authorize the healthcare provider to release the information listed above, which may include the following:
Drug Abuse, Substance Abuse, Psychological/Psychiatric issues and/or AIDS/HIV.

Patient Signature

_____ Date _____

Person Authorized to Sign for Patient

_____ Date _____