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Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

SSN: _____ Daytime Phone: _____

Information To:	Information From:
_____	_____
_____	_____
_____	_____

Please release the following information:

__ Entire Record __ Problem List __ Progress Notes

__ History/Physical Exam __ Labs __ Immunizations

__ X-Rays/Imaging __ Other: _____

Purpose for Record Disclosure:

__ Continued Patient Care __ Legal/Attorney __ Disability Determination

__ Personal Use __ Insurance Claim/Determination

__ Other: _____

I understand the information released is for the specific purpose as stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke/resend this consent (in writing) at any time except to the extent that action has been taken in reliance to it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date