AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

Patient Information:

Patient Name: _____

Address: _____

_____

Date of Birth: _____ SSN: XXX-XX-_____

Authorization for Release

I, _____, hereby authorize the following individual at the following address:

_____

_____

_____

_____

to release, disclose and deliver the medical information described below

- ○ Comprehensive overview of chart (H&P, progress notes, clinical summaries, admit notes, discharge summaries, operative notes, ER notes, EKG)
- ○ Lab Reports
- ○ Imaging / diagnostic Reports
- ○ Pathology Reports
- ○ Operative Reports
- ○ Emergency Department Notes
- ○ Other:_____

to the following provider/facility/entity

Apogee Health Promotions
Andrea Oliver, DNP, APRN, FNP-C
105 Cottage Road, Ste B
Carthage, Tx 75633
Phone: 903-693-3400 Fax: 903-693-3414

the purpose/reason for this release of information is: _____

_____ _____

Patient's Signature or Patient's Representative | Date

_____ _____

Printed Name of Patient's Representative | Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS

HIPAA Authorization For Release of Medical Records