GoPrivateMD

Authorization to Release Medical Records

Name of Patient _____

Date of Birth _____

I authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient. I request that the designated record custodian of all covered entities under HIPPA identified below disclose full and complete protected medical information

INFORMATION TO BE RELEASED OR ACCESSED: History & Physical, Consultation Report, Emergency Room Record, Operative Reports, Discharge/Death Summary, Face Sheet
Lab/Path Reports, X-Ray Reports/Images, ECG Copy/Report

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

FROM:

_____

TO:

GoPrivateMD, LLC
Thomas A. Pascuzzi, MD
8208 Louisiana Blvd NE Suite B
Albuquerque, NM 87113

Fax: 505-508-5249

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____ Signature: _____

Patient or Representative

_____

Print Name of Legally Authorized Representative