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## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION(PHI)

Medical Record release
To: Atlantic Internal Medicine

## From Another Facility/Provider

At my request I hereby a	authorize:		
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To disclose the followin	g information:		
Medical Records (Please	e Specify)		 
Imaging & Diagnostic St	tudies & Report		 
For the date range			 
This authorization is val	id for six (6) months from t	he date of execution.	
Patient Name (Please Pr	rint Clearly)		 
Date of Birth			 
Signaturo		Dato	

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