AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MARSHALL PRIMARY CARE LLC
131 Golfview Dr NE
Arab, Al 35016

PHONE: 256-640-8416 FAX: 256-640-8450

PATIENT NAME**:** _____ DOB**:** _____

I hereby authorize Marshall Primary Care to:

__ Request health information from

__ Send health information to

Please specify Facilty/ Provider Name:

_____

Location: _____

Phone: _____

Fax: _____

Please specify the health information that is to be released:

___ All information regarding assessment, diagnosis, & treatment of patient's condition, concern, or disease.

___ All information regarding care received by patient between dates of _____ and _____.

___ Other information (specify) : _____

Authorization:

_____ _____

Signature of Patient or Authorized Representative Date