

EAGLE DRIVE  
  
FAMILY MEDICINE

I authorize Eagle Drive Family Medicine to release my medical records to the following physician/facility as needed for continuation of care. I understand that records may contain any information from previous providers, information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease and I am authorizing release of this information with my signature :

Physician's/Facility Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone : \_\_\_\_\_

Fax : \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_