

Rev 4/16/03

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name	Patient's Date of Birth
Patient's Street Address	Social Security Number
City, State, Zip Code	Phone Number
I, the undersigned, hereby authorize	
☐ to release copies of medical re-	
Name of Person or Agency	Phone Number
Address	City, State, Zip Code Fax Number
Dates of Service: to be released) The medical records to be released) The medical records to be released and/or alcohol diagn [] Abstract (Summary, Op Report, Paths, Consults, H&P, lab work) [] Emergency Room Record [] Outpatient Surgery [] Discharge Summary [] Admission History and Physical [] Consultation Report	is authorized to release the following: (Please check information cleased may contain medical information pertaining to mental cosis and treatment. [] Alcohol / Detox / Drug Abuse [] X-ray, EKG, EEG, Labs, Cardiopulmonary [] Physical Therapy/OT/Speech [] Nuclear Medicine [] Clinic [] Mental Health/ Psychiatry [] Other
may be revoked by me at any time in writing exce LifeBridge Health Notice of Privacy Practices. It	year unless otherwise indicated. The consent to disclose information upt to the extent that action has been taken in reliance thereon, as set forth in the understand authorizing the use or disclosure of the information identified
information is not authorized without specific con	nsure healthcare treatment. Subsequent re-disclosure or recopying of this sent of the patient or authorized representative as provided in the Annotated *Photo Id may be requested at the time of release.
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