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Authorization for Release of Medical Information

*PATIENT'S NAME_____*DOB:_____

*CELL PHONE:_____E-MAIL:_____

I hereby authorize(Name of doctor/Medical facility) *_____,

its Director or designee, to release information contained in the medical records of the patient identified above in according with Federal Regulation and/or communication made by me.

1. NAME(IF DIFFERENT FROM THE ABOVE), ADDRESS, FAX# or E-MAIL TO WHOM THE INFORMATION IS TO BE RELEASED FROM:

   NAME: _____

   ADDRESS:_____

   *FAX: (___)_____ OR EMAIL:_____

2. SPECIFIC INFORMATION TO BE DISCLOSED

   __ ENTIRE MEDICAL RECORD

   __ PARTIAL MEDICAL RECORD_____

   _____

   _____

3. PURPOSE AND NEED FOR SUCH DISCLOSURE:

   - Continue Medical Care
   - Other_____

4. This consent is a subject to revocation at any time expect
5. Without expressed revocation, this consent expires 90 days subsequent to signing, or on the date set forth below, or for the following specific reasons

   DATE:_____ OR EVENT:_____

   CONDITION:_____

   NOTE: A COPY OF THIS AUTHORIZATION IS VALID AS ORIGINAL

*Signature of Patient/Legal Representative: _____*DATE:_____

(*) MANDATORY FIELDS