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Authorization for the Release of Medical Information From Other Healthcare Facilities

TO: ____

PHONE #: ______________________ FAX #: ______________________

I hereby authorize you to release any information including the diagnosis and any records of my treatment or examination rendered to me during the period from: ____________________ to ____________________.

Patient Name: ______________________________________

Date of Birth: ____________________ S.S.# ____________________

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

______________________________ / ______________________________

*Signature of Patient/Patient's Personal Representative*** *Printed Name*

______________________________ / ______/______/______

Relationship, if not Patient *Date Signed*

Requesting Provider: Katta / Epstein / Huber / Domagtoy / Medina / Dozack / Simmons

Please return this form with medical records:

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