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Authorization for Release of Medical Care Information

Patient Name: _____ D.O.B. _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

RELEASE TO / FROM :

INFORMATION REQUESTED:

_____ Chart note from _____ to _____ Medication List

_____ Lab work from _____ to _____ X-Ray Reports

_____ Other _____

FOR THE PURPOSE OF :

_____ Transfer of Care

_____ Personal Records

_____ Insurance Information

_____ Attorney

_____ Other

This authorization will expire in 90 (ninety) days and may be revoked any time prior to this deadline. I understand and agree to pay a copying fee to cover the cost of transfer.

Signature of Patient

Date

Signature of Witness

Date