Circle of Life Family Medicine

Board Certified Family Medicine

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Authorization for Release of Medical Information

Your medical records cannot be released until this form is completed and signed by the patient, parent or legal guardian.

THERE IS A PROCESSING FEE ASSOCIATED WITH THE REQUEST FOR RECORDS.

Patient Information:

Patient Name _____ Date of Birth _____
Address _____

Disclosing Provider

I hereby authorize _____M.D./D.O.
Address _____
_____
Phone Number _____ Fax Number _____

To release the following (please specify):

□ All records
□ All records EXCEPT _____
□ ONLY records relating to _____
□ Records of treatment from _____ t o _____
□ Other _____

Receiving Provider

To: _____ M.D./D.O.
Address: _____
_____
Phone Number _____ Fax Number _____

Purpose of Disclosure

_____

Statement of Understanding and Signature:
Your signature indicates that you agree to the disclosure of release of medical information described above and that you understand that this authorization is valid for 90 days from the date of the signature. You may revoke this authorization at any time by sending a written request for revocation to the disclosing provider named above. This revocation, however, will not affect any actions taken by the releasing provider before he/she received written revocation.

Name _____ **Date** _____
Signature _____

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