Authorization for Release of Medical Information

I,_____, do here consent to and authorize_____

to disclose to_____

(address)_____

(fax)_____(phone)_____

Information in my medical records, including office notes, x-ray report, CT, MRI, bone scan, other medical reports and demographic information which are part of my medical record. I understand that this protected health information and if this health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

This authorization expires on _____

The following information is strictly for purposes of identification.

My date of birth is ___/___/___

My social security number is ____-____-___

Patient's Signature_____ Date_____

Additional consent from Patient's Parent or Guardian

Signature_____ Date_____

Relationship to Patient_____

Witness_____ Date_____