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Authorization for the Release of Medical Information

NAME:____

ADDRESS:____

CITY, STATE, ZIP:____DATE OF BIRTH:________________

Driver License: ________________SOCIAL SECURITY #: ______/_____/_______

TELEPHONE #: Home:________________WORK #:_______ EXT.:___________CELL PHONE #:________________.

Email address:___________________________Alternate Email address: ___________________________

I hereby request: Name:_____________________________
Address:____
City:______________State:________Zip:_______

Phone #:_________________Fax #:________________

to furnish a copy of the medical records of the above named patient for the period of _____________ to _______________, or medical records pertaining to or consisting of:
____
____
____
____

to Dr. Trombley at the above address or secure fax number. Purpose of Release: ______

I hereby release your physician and employees from liability associated with release of this information. I understand this information will be disclosed to me or the above named physician from records whose confidentiality is protected by Federal Law. I understand that Federal regulations prohibit you from making any further disclosure of this information without specific written consent from me.

SIGNATURE: ____DATE:________________

PARENT/GUARDIAN:____CELL PHONE: ________________________

PARENT/GUARDIAN SIGNATURE:_____________________________RELATIONSHIP: ______________________________