



## MEDICAL INFORMATION RELEASE

Last Name	First Name & MI	Social Security	Date of Birth
Address			

I \_\_\_\_\_, do hereby consent to and  
Patient's name or guardian

authorize \_\_\_\_\_ to disclose to  
Record's Custodian Name

\_\_\_\_\_,  
Name of Covered Entity / Attention To

at \_\_\_\_\_  
Covered Entity's Address

for the purpose of \_\_\_\_\_  
State Reason

information from within my medical records relating to my identity, diagnosis, prognosis, or treatment. However, I do not give permission for any other use or re-disclosure of this information. Date of the information to be copied: \_\_\_\_\_ to \_\_\_\_\_.  
Start date End Date

The information to be released is:

- Face Sheet
- History & Physical
- Evaluation
- Other (Please Specify): \_\_\_\_\_
- EXCEPTION: I do not give permission to release (please specify): \_\_\_\_\_
- Progress Notes
- Consultation
- Laboratory Results

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it was given.

Responsible Party Signature	Relationship	Date
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