ALPHA FAMILY MEDICINE INC.

Enhancing Life & Excelling in Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize _____

Patient Name Hospital / Physician Name

release my Medical Records to _____.

Please release the following information for Date of Service: _____.

_____ Discharge Summary _____ Consult Report _____ ER Reports

_____ History & Physical _____ Lab Report _____ Eye Exam Report

_____ Operative Report _____ Radiology Report _____ Mammography Report

_____ Other Reports: _____

Social Security Number: _____ Date of Birth: _____

_____ Please FAX the records to: _____

_____ Please Mail the requested medical records to the address at the bottom of this page.

I understand this authorization includes release of medical records, which may include information regarding Human Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, Venereal disease, and or any other statutory protected disease. This authorization and consent will expire 180 days following the date signed. I understand that I may revoke this authorization and consent in writing at any time except to the extent that action has been taken in reliance thereon. If I sign for my minor child, I consent that I am the custodial guardian. Furthermore, I understand that these records are for the purpose of continuity of care and cannot be further released or disclosed.

_____ Date: _____

Patient/Guardian Signature

_____

Relationship to Patient

_____ Date: _____

Witness Signature

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