AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print):

Patient's Name: _____

Date of Birth: _____

Phone #: _____

PLEASE RELEASE ALL MEDICAL RECORDS

FOR TRANSFER OF PATIENT CARE

FROM:

PHYSICIAN'S NAME_____

NAME OF PRACTICE: _____

PRACTICE PHONE #: _____

PRACTICE FAX #: _____

TO:

FAIRFIELD MEDICAL ASSOCIATES

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory / x-ray results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS

Patient: _____ Date: _____

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