RELEASE OF INFORMATION CONSENT FORM

Release to: _____

Address: _____ City/State/Zip: _____

Reason for Release: _____

_____ Initial — I hereby authorize _____ to furnish the above-named individual or company with all medical data they may request, as listed below, concerning my illness or injury.

_____ Initial — This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked it shall terminate six months from the date of consent without express revocation.

_____ Initial — I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychiatric diagnosis under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.

_____ Initial — I further understand that I have a right to receive a copy of this authorization upon request.

Copy Requested: ☐ Yes ☐ No Copy Received: ☐ Yes ☐ No

Identifying Information:

Patient's Name at Time of Study: _____
(Please Print)

Attending Physician: _____

Date of Birth: _____ Date of Treatment: _____

Information Requested:

☐ Discharge Summary ☐ History and Physical ☐ Operative Report ☐ X-ray

☐ Consultation ☐ Laboratory ☐ EKG, EEG ☐ Other: _____

Signed:

Patient, Parent or Legal Guardian: _____ Date: _____

Address: _____ City/State/Zip: _____