Please use a Fax Cover Sheet with this form

Eagle Physicians and Associates
Authorization for RELEASE of Medical Records

Authorization must be completely filled out (printed or typed) to be valid. Iron Mountain works under agreement with Eagle Physicians to process transfers of Medical Records.

I, (Full Name): _____ DOB: _____

Street Address/City/State/Zip: _____

Daytime Phone: (_____) _____-_____

Authorize:	❑ Gastroenterology	❑ Oak Ridge	❑ Triad
❑ Brassfield	❑ Guilford College	❑ OB-GYN	❑ Village
❑ Cardiology	❑ Lake Jeanette	❑ Tannenbaum	
❑ Endocrinology	❑ Oak Ridge	❑ Other _____	

To release information from the medical record of: _____
Full Name DOB

To: _____

Street Address/City/State/Zip: _____

Daytime Phone: (_____) _____-_____

Please Send: (Eagle Physicians sends 3 years of records as "ALL" records on all patients unless otherwise indicated here _____)

❑ All my records (including X-ray reports and other reports).

❑ Specific Labs ❑ Specific X-rays ❑ Specific progress notes (dates_____ to_____)

❑ Complete Bone Density Reports (all reports, complete scans and images.)

For the purposes of: ❑ Continuation of Care ❑ Patient Request ❑ Transfer ❑ Life Insurance ❑ Legal ❑ Social Security ❑ Other_____

I understand that I am authorizing the release of all medical information from my chart unless specifically restricted as indicated below:

❑ HIV/AIDS or related testing ❑ Mental Health ❑ Chemical Dependency (drug/alcohol)

This authorization is valid for 180 days from the date signed or until _____ whichever is shorter. This authorization may be revoked at any time by notifying your physician's site in writing, except when this authorization was obtained as a condition of acquiring life insurance coverage. Eagle Physicians & Associates and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected.

_____ _____ _____
Signature of Patient or Legal Guardian Date Relationship to Patient, if not Patient

AR # _____

NOTICE: There will most likely be a charge for this service.