AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Birth date:

ID #:_____ Telephone:

Address:

Release From: (Name of Facility of Clinician Releasing Information):
I authorize release of my medical records from:

Facility/Name of Physician: _____.Saint Peter's University ____ Other

(Specify)

Address: (If different form Saint Peter's University facility):

Release To: (Name of Facility/Clinician/Person Receiving Information):
Please send my medical records to:

Name:_____ Telephone #:

Complete Address:_____ Fax #:
Release Information:
Reason: ___ Moving out of area ___ Requirement for school ___Personal file
Please Release the Following: (check all that apply)
____ Immunizations
____ Laboratory Results Only (specify)
____ Other information (specify)

Consent:
This information is intended by the above named recipient only. I have a right to receive a copy of this authorization. I may revoke this authorization at any time in writing

Signature of Patient:_____ Date:

Witnessed by:_____ Date: