AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print)

Patient's Name: ________________________

Date of Birth: ___________________________

Phone Number: ___________________________

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

FROM: ____

PHONE NUMBER: ____

FAX: ____

TO: ____

ATTN: ____

PHONE NUMBER: ____

FAX NUMBER: ____

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 Signature: ________________________________ Date: ________________

Liberty Doctors Representative: ___________________ Date:________________