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RELEASE OF MEDICAL INFORMATION

DATE_____

To:_____

Phone:_____
Fax:_____

You are hereby authorized and requested to furnish to:_____

_____

any and all Medical Information, history, records, diagnosis, reports, or x-rays in your possession concerning the undersigned

_____ _____
Patient Signature **Date of Birth**

_____ _____
PATIENT (PRINT) Approved: Attending Doctor

_____
Signature of Parent or Guardian

PLEASE FAX OVER ANY REPORTS ASAP

CONFIDENTIALITY/HIPPA NOTICE: The personal health information contained herein is privileged and highly confidential. It is intended for the exclusive use of the person to whom it is addressed and is to be only to aid the recipient in providing healthcare services to this patient. Any other use or disclosure is a violation of Federal Law (HIPPA) and will be reported, If this communication has been received in error, please notify us by telephone immediately, collect if necessary (520) 321-1171