Request and Authorization to Release Medical Information

Patient Name: ______________________________________ Date of Birth: ________
Address: ____ Phone: ______________
City/State/Zip: ____

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KI kxg"P cwtcn"Hco kn{"J gcnj "Rgto kuukqp"\q"TGNGCUG"o {"o gfkecn"tgeqtf u"\q<
I Give Natural Family Health Permission to DISCUSS my medical records with:

Facility Name/Provider Name: ____
Address: ____
Phone: _______________________________________ Fax: ______________________
Reason for Transfer: ____

Indicate requested records to be sent or obtained:

Health records including chart notes
Lab Results
Imaging Reports
Mental Health Records (must be initialed to be included with other documents)

I understand that this authorization is valid for 6 months from the date of signing unless revoked in writing earlier. The *only exception* is when the action has already occurred as instructed in the consent.

Signature of Patient or Guardian: X ___________________________Date: ________

Relationship to Patient: ____

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