# Request for Medical Information

1. **Authorization :** I authorize disclosure of information and health records as described below:
   Name of Patient: _____ Date of Birth: _____
   Telephone: _____

2. **Record Holder:** _____
   Address: _____
   Phone: _____ Fax: _____

3. **Records May Be Released To:** _____
   Address: _____
   Phone: _____ Fax: _____

4. **Type of Information:** This authorization is limited to the following types of information -
   ___All Records ___Discharge Summary ___Progress Notes
   ___Operative/Procedure ___History/Physical Exam ___Treatment for Alcohol/Drug Abuse
   ___Consultation Reports ___HIV Test Results
   ___Emergency Department Reports ___Psychiatric Records
   ___Laboratory Reports ___Billing Information ___Radiology/Nuclear Medicine Reports ___Other_____

5. **Dates of Service:** All ___ or From _____ To _____

6. **Use if Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please check all that apply.**
   ___Continuing Medical Care ___Second Opinion ___Personal
   ___Insurance ___Legal ___Other (please specify) _____

7. **Duration:** This authorization is valid for 90 days from the date next to my signature, unless otherwise noted here: _____

8. **Signature:**
   Print Name: _____
   Signature: _____
   Date: _____
   If signed by other than patient, indicate your relationship to the patient: _____
   Witness Signature: _____
   Date: _____