AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

First Name: _____Last Name: _____

Date of Birth: _____SSN: _____Phone: _____

Address: City: State: Zip: _____

_____

*****Please check one of the following*****

☐ I am authorizing Extended Care Health Professionals, PLLC to release records to another party or myself.

☐ I am authorizing another Party to release records to Extended Health Care Professionals, PLLC Please give details of the doctor & facility which we are releasing/ receiving records to/from below.

(A SEPARATE FORM IS REQUIRED FOR EACH DOCTOR'S REQUEST)

Doctor: _____Facility: _____

Address: City: State: Zip: _____

Phone: _____ Fax: _____

We Request the Following Records Only:

☐ Progress notes last 2 visits ☐ Most recent lab results ☐ Most recent radiology

Please Select Reason for Disclosure:

☐ Changing Physicians Continuing Care ☐ 2nd Opinion ☐ Insurance/Legal ☐ Other: ☐

Patient (or Representative) Signature: _____ Date: _____

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