# FAMILY MEDICAL ASSOCIATES & PEDIATRICS

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## *AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION*

Patient's Name: ______________________________________________

Last Four of Social Security #: ____________________ Date of Birth: ____________________

Reason for Release: (circle) New PCP Seeing Specialist FMLA Legal

Other: ______________________________

______________________________________________________________

I authorize Family Medical Associates & Pediatrics to:

➜ **(Circle One)** ➜

**RELEASE TO** or **OBTAIN FROM**

Doctor & Office / Name: ______________________________________

Address: ______________________________________________

______________________________________________

Phone: __________________________ Fax: __________________________

E-Mail: ______________________________________________

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I request a copy or summary of the following medical records:

- □ Most Recent Labs & Office Notes
- □ Other ______________________________________________

For dates of service from __________________________ to __________________________

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Expiration Date: This authorization shall automatically expire six (6) months after the date of signature and covers information only prior to that date. I understand that I may withdraw this consent at any time but the revocation shall not be retroactive to the release of information made in good faith. I also understand that any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.

______________________________ ______________________________

Patient (or person authorized to consent for minor) Date