AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT

Name (Last, First, MI): ____ DOB: _____________ SSN: ______________________

Address: _______________________________ City, State, Zip: ____________________________ Phone: ________________

INFORMATION TO BE RELEASED FROM

Name of health care provider, clinic, or facility ____
Address: ____
Date Requested: ______________________________ Date Needed By: ___________________________

INFORMATION TO BE SENT TO

By Fax, TO: ______________________ at Consultative Health and Medicine FAX: **855-356-4042**

By Mail TO:

Consultative Heath and Medicine, P.A.
5520 Ridgewood Cove
Minnetrista, MN 55364

INFORMATION TO BE RELEASED

PLEASE RUSH: Our clinic is assuming primary care for the patient and need the following information for continuity of care.

X Most recent H&P and 6 months of MD/NP clinic visits
X Problem List
X Medication List
X Lab and Xray reports from last 6 months
X Immunization Record

Other ____

PATIENT AUTHORIZATION

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization, in writing, at any time. I understand that there may be a copy fee associated with the medical record release. I understand the expiration of this authorization is one year from the date signed.

____ ______________________________ ______/______/__________
Signature Printed Name Date

(Patient, legal guardian or legal representative)

If you are the legal representative, please include with this form a copy of supporting documentation of Health Care Power of Attorney or Guardian/Conservator authority so that medical records can be sent without additional delay. Thank you.