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Authorization for release and Examination of Medical Records (PHI)
from one physician to another physician setting.

Patient Name: _____ **Date of Birth:** _____

Address:_____

I hereby authorize and request that you release the records and information to the entity below:

To:_____

_____

I hereby authorize, _____, to furnish a complete copy of my medical record, also known as PHI, and all related data to the above mentioned entity for the following dates: _____ to _____. I am aware that there may be information in the medical record that relates to: **substance abuse, mental illness, HIV or AIDS that is a highly confidential level.**

Specific records to be released as identified: ____ all medical records _____ x-rays

I am aware that I can revoke this release at any time prior to the records being released to the above named entity and that this release is valid for 90 days.

Signature of Patient/legal guardian **Date:**

_____ _____

This practice does not routinely release records from other providers because we are not sure that the records are complete or have not been modified.