FAMILY MEDICINE SPECIALISTS

Doctor · Health · Family Medicine Practice

Medical Record Department

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

PLEASE PRINT CLEARLY (Must be completely filled out to process)

Patient Name: ______________________________ DOB: ____________
Street Address: ______________________________ Apt: ____________
City: ____________________ State: ____________ Zip: ____________
Phone: ____________________ Email: ______________________________

I Authorize:
Name of Physician/Physician Office: ______________________________
Street Address: ______________________________ Apt: ____________
City: ____________________ State: ____________ Zip: ____________
Phone Number: ____________________ Fax: ______________________________

To Release information from My/My Family Member Medical Record via fax/mail/phone to:
Name of Physician/Physician Office/Law Office/Insurance/Persons/ETC…:
____
Street Address: ______________________________ Apt: ____________
City: ____________________ State: ____________ Zip: ____________
Phone Number: ____________________ Fax: ______________________________

Limitation: (All information will be sent unless otherwise stated below)
□ HIV/AIDS □ Psychiatric □Substance Abuse
□ Any other limitations: ______________________________
□ Only send records in regards to: ______________________________

This authorization will automatically expire one year from the date signed unless otherwise stated. I understand that I may revoke this authorization at any time except to the extent that action has previously been taken with regards to consent of release.

Patient Signature: ______________________________ Date: ____________

If not patient, Relationship: ______________________________

Office use only
Office Location: ____________________ Staff: ____________________ ENC 12/22/2017
Medical Records Phone: 847-526-2151; Fax: 847-526-2017; Email: medrecs@fmsmed.com