AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE

NAME ____

DOB ____ **SSN** ____________________________________

PROVIDER ____ **FAX** ____________________________________

I authorize the named Healthcare Provider to release the information or records specified to CARDINAL HEALTHCARE upon request in person, by fax, or by mail to the address or fax number specified at the time of the request.

Records authorized to be released:

- LABWORK DATED FROM _______________ TO _______________
- OFFICE NOTES FROM _______________ TO _______________
- RADIOLOGY REPORTS DATED FROM _______________ TO _______________
- CONSULT NOTES FROM ___________________________________
- ALL RECORDS ON PATIENT FROM _______________ TO _______________

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the Healthcare Provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed and that Cardinal Healthcare may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Authorized Signature ______________________________________ Date _______________________

Name of Representative ____

Relationship to Patient ____

PLEASE FAX REQUESTED RECORDS TO (478) 412-2881 OR

MAIL TO 601 FERNCREST DRIVE SUITE 2 SANDERSVILLE, GA 31082