

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 524 SPARTA ROAD SANDERSVILLE, GA 31082