AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL RECORD INFORMATION

DR. DEBORAH LONGWILL

Patient Information

Patient Name _____ *Date* _____

Address _____ *Phone* _____

City _____ *State* _____ *Zip* _____

Release Information To (check one):

- ☐ I hereby authorize Dr. Deborah Longwill to release my medical record information to the physician or facility listed below.
- ☐ I hereby authorize the physician or facility listed below to release my medical information to Dr. Deborah Longwill.
- ☐ I hearby request and authorize Dr. Deborah Longwill to release my medical records to myself and/or family member listed below

Name/Facility _____ *Attention* _____

Address _____ *Phone* _____

City _____ *State* _____ *Zip* _____

Delivery Preference (check one):

☐ Mail copies to address listed above ☐ Hold for patient pick-up ☐ Phone / Fax _____

Information To be Released (check one):

☐ Progress notes only ☐ Laboratory notes only ☐ Other (specify records needed):

☐ Pathology reports only ☐ All records _____

Purpose for Need or Disclosure (check one):

☐ Continued patient care ☐ Insurance claim/application ☐ Other

☐ Attorney/legal ☐ Change of physical/relocation _____

I understand that the information release is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Dr. Deborah Longwill for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

_____ _____

Patient Signature *Relationship to Patient (self, parent, spouse)*

Please fax completed form or mail to address below, attention Medical Records.

For office use only. Staff Initial: _____ *Date/time handled:* _____ *Means of transmittal:* _____