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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____

Patient birth date: ____

Name and fax number of clinic that records are to be sent FROM:

____
Doctor or clinic name

____
Address

____
Phone number Fax number

This is to authorize the above named health care provider to provide the Bright Medicine Clinic with the following specific medical records:

___ Chart Notes

___ Laboratory results

___ Imaging reports

___ Other ____

I understand that I can revoke this authorization at any time by writing to the health care 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.

A copy of this form may be utilized with the same effectiveness as the original.

This authorization form will expire 180 days from the date of the signature below.

Date: ___________________ Print Name: ___________________________

Signature: _____________________________