PATIENT NAME _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

PATIENT NAME _____

DATE OF BIRTH _____

PHONE _____

TO WHOM RECORDS WILL BE SENT

The Lady with the Lamp, PLLC.

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Kingwood, TX 77345

Fax: (844) 899.4223

Office: (281) 706.9232

Email: OfficeAdmin@TheVisitingNP.com

FROM WHOM RECORDS WILL BE RELEASED

_____

_____

_____

_____

_____

PLEASE RELEASE THE FOLLOWING

☐ Problem list ☐ History & Physical ☐ X-Ray reports ☐ EKG reports
☐ Labs ☐ Consultation notes ☐ Progress rotes ☐ Immunizations
☐ Radiology reports ☐ Hospital records ☐ Emergency records ☐ Other _____

INCLUDING INFORMATION (IF APPLICABLE) PERTAINING TO

☐ Mental health ☐ Drug/Alcohol ☐ HIV/AIDS ☐ Other _____

THIS INFORMATION IS BEING RELEASED FOR THE FOLLOWING PURPOSE(S)

☐ Continued patient care ☐ Personal use ☐ Attorney / Legal
☐ Insurance claim ☐ Disability determination ☐ Other _____
☐ Radiology reports ☐ Hospital records ☐ Emergency records

I understand that the information is for the specific purposes stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance of it.

SIGNATURES

To the best of my knowledge, the above information is complete and correct and I authorize the release of medical records to the party listed above.

_____ _____
Signature of patient, parent, guardian, or personal representative Date

_____ _____
Printed Name of patient, parent, guardian, or personal representative Relationship to patient

_____ _____
Reviewed by Date