

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

I authorize Dr. Tyson to Release information to:

AND/OR

I authorize Dr. Tyson to obtain information from:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip

City, State, Zip

Phone #/Fax # (include area code)

Phone #/Fax # (include area code)

Purpose of this Request: _____

Specific Information Authorized (select one or more as appropriate):

History & Physical

Consultation Reports

Operative Reports

Radiology Reports

Laboratory Results

Pathology Reports

Emergency Room Reports

Other: _____

Diagnostic Reports (i.e., EKG, EEG, Sleep Study)

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Dr. Tyson, except where a disclosure has already been made in reliance on my prior authorization.
- Release of HIV – related information requires additional information.

Expiration of Authorization:

Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form

Patient Signature

Date

Guardian Signature

Date