Edward P. Tyson, M.D.
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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

_____
Address

_____
City, State, Zip

_____
Phone #/Fax # (include area code)

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone #/Fax # (include area code)

Purpose of this Request:_____

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

___History & Physical
___Operative Reports
___Laboratory Results
___Emergency Room Reports
___Diagnostic Reports (i.e., EKG, EEG, Sleep Study)
___Consultation Reports
___Radiology Reports
___Pathology Reports
___Other:_____

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