DOWNTOWN DOCTOR

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AUTHORIZATION FOR RELEASE OF INFORMATION FROM US

I, the undersigned, hereby authorize Dr. Freeman at The Downtown Doctor medical clinic to release the information specified to the doctor or medical practice I name below.

Doctor's Name _____

Practice Name _____

Mailing Address _____

_____

Phone Number _____

Fax Number _____

The reason for this release of information is: ☐ Continuity of care

☐ Other (please specify): _____

I understand that my records are confidential and cannot be disclosed without written authorization, except as otherwise provided by law.

This authorization is valid for six (6) months and may be revoked by the patient, orally or in writing at anytime prior to that expiration date.

Information to be released should include all history, physical exam and progress notes, lab and X-Ray reports, and all correspondence relating to my medical care unless otherwise specified below.

Your prompt attention is greatly appreciated.

_____ _____
Patient's Printed Name Patient's Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date

According to state and Federal law, the statements below must be signed in order to process your records requests if such information exists in your chart(s).

Please include the following information in my records request:

Mental Health Records _____
Signature of Patient or Patient's Legal Representative

Alcohol/Substance Abuse Records _____
Signature of Patient or Patient's Legal Representative

HIV Records _____
Signature of Patient or Patient's Legal Representative