

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patients Legal Name: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____ Phone Number: _____
Date of Request: _____ Date Needed: _____

I authorize PCAG to obtain information **from other doctors, hospitals, etc:**

NAME OF PROVIDER OR FACILITY

ADDRESS

CITY STATE ZIP

PHONE (with area code)

FAX (with area code)

I authorize PCAG to release information to **parents, other doctors, etc:**

NAME OF PROVIDER OR FACILITY

ADDRESS

CITY STATE ZIP

PHONE (with area code)

FAX (with area code)

PURPOSE OF THIS REQUEST (check one): Healthcare Insurance Coverage Personal Transfer of Care Other

TYPE OF RECORDS REQUESTED (check one):

All medical records related to a specific illness or injury.

SPECIFY ILLNESS OR INJURY

DATE(S) OF TREATMENT

Treatment summary

(including history/physical, laboratory tests & x-ray reports, operative and pathology reports)

Specific Information (select one or more if applicable):

Procedure Report

History & Physical

Laboratory Test Results

X-Ray Reports

Other: _____

Copy of the entire medical record, as allowed by law.

NOTE: AUTHORIZATION VALID FOR THIS REQUEST ONLY.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- If the person or facility receiving this authorization is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.
- There will be a charge for the requested records. Doctors' offices will not be charged for the request.
- Please allow 7-10 business days from the date of this request for records to be available for pickup or delivery.

Signature of Patient or Patient Representative: _____

Relationship to Patient (if requester is not the patient): _____

Please FAX to (313) 833-4648