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): _____