Authorization for release of medical records

Patient Name:_____Dob:_____

Address:_____

Phone:_____

I, _____ hereby voluntarily authorize the disclosure of information from my health records **FROM**
_____(business name),

_____ (provider),

_____ (address),

_____(phone)_____(fax).

Information requested: Medical records including labs, immunizations.

Purpose of release: Transferring medical care

The information is to be provided **TO**:

Patients Choice Primary Care
April Andrews FNP-BC
260 West Main Street, Dublin VA 24084
Phone: 540-307-5495
Fax: 540-307-5709

Patient Signature:_____Date:_____

(Please make a copy of this release for your records)
HIPAA Authorization for Release of Medical Records