AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO REED FAMILY MEDICINE

Patient's Full Name_______________________________________ Date of Birth__________________

Street Address ____

City, State, Zip____

I hereby authorize ____
(office we are requesting information from) to release my entire medical record for transfer of care.

PLEASE FAX RECORDS TO: 442-200-2368

I hereby authorize disclosure of the health information as indicated on this form. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it is will not affect any information released prior to notification of cancellation.

____ ______________________
Signature of individual or guardian or Personal Representative of patient's estate **Date**

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