AUTHORIZATION to RELEASE MEDICAL RECORDS/INFORMATION

Physician or facility to provide records:______________________________

Facility Address:______________________________ Phone__________

Patient's name:____

Street:__________________City:_________State:_____Zip Code:______

Social Security #:__________________DOB__________________

Person to receive records (name and address): DO NOT FAX RECORDS!!

Dr. Alan P. Aboaf
Dr. T. Scott Gilmer
Lisa Lumley, FNP-C
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I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

Initials

_____ Drug abuse if any

_____ Psychological or psychiatric conditions if any

Initials

_____ Substance abuse if any

_____ AIDS/HIV if any

Release these records: DO NOT FAX RECORDS!

Initials

1. Only records generated by this facility (not including records received from other sources)..._____
2. Only some portion of records maintained at facility (specify below)............._____
3. All medical records at this facility.._____

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Expiration or revocation of authorization-I understand that I may revoke this authorization at any time.

Use of copies-A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print): ________________________

Person authorized to sign for patient: ________________________

SIGNATURE

Patient's signature:

______________________________ Date:__________________