

Initial Here:

Authorization to Release Protected Medical Information

| | | |
|----------------------|-------------|----------------|
| Patient's Last Name: | First: | Date of birth: |
| Street Address: | Cell Phone: | |
| City: | State: | Zip Code: |

I hereby give Samantha M. Winfrey, NP authorization to (specific):

| | | |
|--|---|--|
| <input type="checkbox"/> Release information to: | <input type="checkbox"/> Obtain information from: | <input type="checkbox"/> Discuss information with: |
| Company/Provider/Person Name: | | |
| Address: | | |
| Phone: | Fax: | |

Covering the period(s) of treatment from _____ to _____ / ALL

Information Requested:

For the purposes of:

- | | |
|--|---|
| <input type="checkbox"/> Records – Date(s) specified above | <input type="checkbox"/> Coordination of care w/ another provider |
| <input type="checkbox"/> Lab Work | <input type="checkbox"/> Moving/Transferring Care |
| <input type="checkbox"/> Records DO NOT need to be sent | <input type="checkbox"/> Insurance/Disability/Legal |
| <input type="checkbox"/> Other (specify)_____. | |

I understand if records are being requested, I must allow a two week processing period.

I understand this authorization will expire in ONE YEAR unless otherwise indicated in writing.

I understand I may revoke or edit this authorization at any time by providing written notification to Samantha M Winfrey, NP.

_____.

Printed name of Patient or Authorized Representative

Date: / / .

_____.

Signature of Patient or Authorized Representative