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Authorization for Release of Health Information

Patient Name: _____
DOB: _____
Authorize:

Name: _____

Address: _____

To Disclose To: Heinen Medical

Release of information of the following:

_____ Progress Notes _____ Lab Results

_____ Radiology Testing _____ Other _____

This disclosure is being made for the following purpose(s):

_____ Continuing Care
_____ Attorney/Court Case
_____ Worker's Compensation Case
_____ Transfer of Care
_____ Insurance
_____ Personal Reasons

This authorization for disclosure of information is effective for one year from the date signed. This informed consent is subject to revocation at any time by written notification only.

Patient Signature: _____ Date: _____
OR
_____
Signature of Legal Representative
Relationship:

_____Legal Guardian
_____Executor of Estate
_____Other
_____Spouse of Deceased
_____Power of Attorney for Healthcare