Release of Medical Records

Patient Name: ____

Address: ____

City: ____________________ **State:** ______________ **Zip:** ______________

Date of Birth: ________________________________

The undersigned hereby consents to and authorizes the release by/to Michael Nazareth, MD-PhD all medical information, reports, progress or office notes concerning their medical or mental condition.

_____ Relevant records deemed pertinent by the treating physician

_____ Progress notes from __________ to __________

_____ Pathology reports from __________ to __________

_____ All records

_____ Other

Records requested are for the continuation of treatment.

I am authorizing the relase of this information being sent from:

____

I am authorizing the release of this information being sent to:

____

This information is limited to the furnishing of the referenced records only and should not be used to communicate orally or for any purpose other than for my medical condition. This request will expire 60 days from date signed.

Signature: ______________________________ **Date:** ____________________

The above-named individual executed this authorization on the above-referenced date and duly executed authorization.