AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information:
Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

Records to Be Released:
Country and Field Service: _____
Time Period: From _____ to _____

- ☐ Xray
- ☐ Lab
- ☐ Physician documentation
- ☐ Nursing documentation
- ☐ Outpatient services
- ☐ All records

Purpose of Release:

- ☐ Continuing care
- ☐ Insurance purposes
- ☐ Legal purposes
- ☐ Other: _____

Authorization: I, the undersigned, hereby authorize the release of my medical records as described above. I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken. I also understand that the records released under this authorization may be subject to further disclosure by the recipient and may no longer be protected by federal privacy laws.

Patient Signature: _____

Date: _____

If applicable, **Guardian's Signature**: _____

Date: _____