

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To (Practice/Doctor Name): _____
Practice Street Address: _____
Practice City, State, Zip: _____
Practice Fax Number: _____

Re: _____ ("Patient")

The undersigned is the _____ (insert relationship to patient) of the referenced Patient who resides at _____. You are hereby authorized to release and provide any/all medical records and other protected health information in your possession relating to the Patient.

These records are to be sent to (Insert family member information, not Dr Berger's):

Name: _____
Address: _____
Fax: _____

Information to be provided:

- () The entire medical record
- () vaccine record [both old vaccine records as well as done under Dr Berger's care]
- () consultation notes for the following dates: _____

- () infusion records for the following dates: _____

- () lab results for the following (name of test and date): _____

I acknowledge the following:

1. I have the right to revoke this authorization at any time by sending written notification to you.
2. Any information disclosed pursuant to this authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Date

Signature _____

Print Name: _____