RECORDS RELEASE/REQUEST

I hereby request and authorize_________________ to release information from the medical record of:

PATIENT NAME____
SS#:_____________________________ DOB:___________________________________

Information requested to be released: ____

From:

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To:

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The reason for releasing this information _______________________________________.

I place no limitations on the medical information released including conditions related to the treatment or mention of alcohol or drug abuse, HIV/AIDS, or psychiatric disorders. I release NFIMG and its employees from any responsibility or liability for the release of medical information.

____

Patient Signature Date

For Office Use Only
By : MAIL_____ FAX_____ P/U on_____