

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: Foxhall Surgical Associates, P.C.

Date: _____

From (patient name): _____

DOB: _____

I hereby authorize the release, disclosure, and delivery as indicated of the specific information described below, only for the purposes and parties also described below. Please complete entirety of form to expedite.

Specific information to be disclosed (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Dictations (Doctor's notes) | <input type="checkbox"/> MRI reports |
| <input type="checkbox"/> Pathology / Cytology reports | <input type="checkbox"/> Other Radiology reports |
| <input type="checkbox"/> ER / PR | <input type="checkbox"/> Operative reports |
| <input type="checkbox"/> Onco Type | <input type="checkbox"/> Clinical / Discharge reports |
| <input type="checkbox"/> Outside Consult (ie: Mayo, AFIP, etc) | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Mammogram reports | <input type="checkbox"/> Radiology Films (i.e. Mammograms) |
| <input type="checkbox"/> PET scan reports | <input type="checkbox"/> All medical records |
| <input type="checkbox"/> CAT scan reports | <input type="checkbox"/> Other: _____ |

Recipient of the records:

- Myself
- Doctor/Facility, list name/address: _____
- _____
- Other, list person(s): _____

Method of delivery:

- Forward/Fax to (list address / fax #): _____
- _____
- Pick up in DC office

Purpose of the request:

- Change of residence/location
- Change of insurance
- Medical Treatment
- Other (specify): _____

Expiration Date: Authorization expires 6 months from date signed unless indicated differently: _____

I understand that by my signature I hereby release Foxhall Surgical Associates, P.C. from any liability if the above referenced documents and/or films are lost, not returned to Foxhall Surgical Associates, P.C., or used by other parties. I also acknowledge that there may be a processing fee collected prior to the release of my records.

Print Name

Relationship if Personal Representative

Signature

Date