

**PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**To:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**From (patient name):** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I voluntarily authorize and direct my health care provider (**Please insert provider name**) \_\_\_\_\_  
\_\_\_\_\_ to release, disclose, and deliver my health information during the term of this  
Authorization 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"/> <b>Other:</b> _____               |

**Recipient of the records:**

- Foxhall Surgical Associates, P.C. (circle one):**  
(Dr. Peter Petrucci, Dr. Michael Palmer, Dr. Martin Paul, Dr. Meredith Garrett, or Dr. Brian Long)
- Myself
- Other, list person(s): \_\_\_\_\_

**Method of delivery:**

- Forward / Fax to **Foxhall Surgical Associates, P.C.**
- Forward / Fax to other (list address/fax #): \_\_\_\_\_
- Pick up in office

**Purpose of the request:**

- Upcoming appointment (Date and time): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**Expiration Date:** Authorization expires 6 months from date signed unless indicated differently: \_\_\_\_\_

I understand that by my signature I hereby release the above healthcare provider from any liability if the above  
referenced documents and/or films are lost, not returned to them, 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