Dr. Laura Mieszerski
Medical Records Request
Authorization

_____ _____
(Name of Patient) **(Date of Birth)**

_____ _____
(Street Address) **(City, State, Zip Code)**

_____
(Phone Number)

Authorizes:

_____
(Name of Physician)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone Number)

_____
(Fax Number)

Release of Records to:

_____
(Name of Physician)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone Number)

_____
(Fax Number)

Information to be Released:

All Clinical Records	Visual Fields	Lab Reports
Office Notes	X-Ray Reports	Photographs

Other (Specify) _____

List other facilities' records to be included when releasing for the purpose of continuing medical care:

_____

_____

For the following dates: _____

In compliance with states statutes which require special permissions to release otherwise privileged information, please release records pertaining to:

Mental Health	AIDS Test Results	Drug Abuse
Developing Disabilities	AIDS-released Disease Diagnosis	Alcoholism

Other (Specify) _____

Purpose or need for disclosure: (circle applicable categories)

Further Medical Care	Payment of Insurance Claims	Legal Investigation
Application for Insurance	Vocational Rehabilitation Evaluation	Personal
Disability Determination		

Other (Specify) _____

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

_____

By signing this form, I authorize you to release confidential information about me, by releasing a copy of my medical records, or a summary/narrative of my protected health information, to the person(s) or entity listed above.

Signature of Patient/Parent/Legal Guardian: _____ **Date:** _____

Patient is:	**Minor**	**Incompetent**	**Disabled**	**Deceased**
Legal Authority:	**Legal**	**Legal Guardian**	**Next of Kin Deceased**	