AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Viewmont Internal Medicine
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Records Requested For:

Patient: ___________________________________ **Birth Date:** __________

I do hereby consent and authorize you to release copies of my medical records including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are part of my medical records. PLEASE NOTE: This authorization includes information concerning cancer, cancer testing, and cancer results. I agree that a copy of the release or a fax of this release shall be as valid as the original release.

____ SEND ALL RECORDS

____ SEND RECORDS FROM (Date)_________to(Date)________

____ (Other) ____

Send Records to:

____

____

____

Patient Signature: ___________________________ **Date:** _________

Witness: ____