AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Viewmont Internal Medicine
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Records Requested For:

Patient: _____

Address: _____

Birth Date: _____

SS# _____

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 All Records To: _____

_____

_____

Patient Signature: _____

Date: _____

Witness: _____