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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME_____

ADDRESS _____

PHONE NUMBER _____**ALTERNATE NUMBER** _____

DOB _____**SOCIAL SECURITY NUMBER**_____

IN CASE OF EMERGENCY _____**PHONE** _____

I, _____**hereby authorize Dr. / Hospital** _____

To release the following medical records to Charis Family Clinic and its associates.

- ☐ **Emergency Room Records**
- ☐ **Face Sheet**
- ☐ **History of Physical**
- ☐ **EKG's**
- ☐ **Echocardiogram Report**
- ☐ **Report(s)**
- ☐ **Psychiatric Consult / History**
- ☐ **Laboratory / X-ray Reports**
- ☐ **Discharge Summary**
- ☐ **Consultation Reports**
- ☐ **Progress Reports**
- ☐ **Doctor's Orders**
- ☐ **MRI Report(s)**
- ☑ **Other** all medical records

To help us expedite the attainment of your medical records, please provide us with the name, address and phone number(s) of your previous primary care physician(s).

Previous Doctor _____**Phone Number**_____

Address: _____**Fax Number**_____

Patient Signature _____**date:**_____

Authorized Representative _____**date:**_____

Witness _____**date:**_____

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