Carol A. Fischer, MD PC
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ Social Security #: ____________________

I request and authorize CAROL FISCHER, MD, PC ____________________ to release healthcare information of the patient named above to:

Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates: ____________________

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☐ Other: **Most recent lab work results, all diagnostic imaging and screening results, and most recent office visit note**

I understand that my medical records are confidential and by signing this authorization, I am allowing the release of my medical information to the requested agency or person as listed above.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____________________ Date Signed: ____________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.