The Redmond Family Medicine Center
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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I Authorize: *(please check one)*

- ☐ **Dr. Dawna Marie Townsend Fixott** To **RECEIVE** records **FROM**
- ☐ **Dr. Dawna Marie Townsend Fixott** To **SEND** records **TO**

_____
Name / Facility Phone Fax

For the following purpose:_____

Patient Name:_____ Date of Birth _____
(Please Print Clearly)

Phone:_____ Social Security Number _____

Other Names Used: _____
(Maiden, etc)

By **INITIALING** the spaces below, I specifically authorize the release of the following medical information:

Initial ____Office Chart Notes
Initial ____Hospital Reports
Initial ____All Medical Records
Initial ____Laboratory Reports
Initial ____Consultation Notes
Initial ____Other (Please Specify) _____
Initial ____Radiology Reports
Initial ____Records Received From Other Providers _____

The following MUST BE INITIALED in order for the information to be released

Note: The following may be on Prenatal Records

____HIV/AIDS related Records ____ Mental Health Information
____ Genetic Testing Information (does not pertain to Prenatal Genetic Testing)
____ Drug/Alcohol diagnosis, treatment or referral information (Federal Regulation, 42 CFR, part 2), requires a description of how much and what kind of information is to be disclosed.

This authorization may be revoked at any time. The only exception is when action has to be taken in reliance on authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for a period reasonably needed to complete the request

Patient Signature:_____ Date:_____
(or Legal Representative)