# REGENCY MEDICAL CENTER P.C

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## Authorization for the Release of General Medical Records

This is to authorize that medical information regarding the following patient be forwarded:

**Patient Name:**_____ **Date of Birth:**_____

**Address:**_____ **City:** _____ **State:**_____ **Zip:**_____

**FROM:**

**Facility/institution**_____

**Address:**_____**City:**_____**State:**_____ **zip:**_____

**Telephone:**_____ **Fax:**_____

**TO:**

**Facility/institution**_____

**Address:**_____**City:**_____**State:**_____ **zip:**_____

**Telephone:**_____ **Fax:**_____

**Purpose of date being requested:**_____

**Disclosure is limited to:**

- ⇒ **1. Records regarding admission and treatment for the following medical condition or injury:**

  _____

- ⇒ **2. Records for the period (dates) from:**_____ **to:**_____
- ⇒ **3. The following specific information:**_____
- ⇒ **4.**_____ **SEND ALL RECORDS. No limitations placed on dates, history of illness, or diagnostic therapeutic information.**

I understand that my records are protected and cannot be disclosed without my written consent unless otherwise provided for in the law. I also understand that I may revoke this consent at anytime except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically 90 days after signing.

Date:_____ Signed:_____
Patient or Parent/Legal Guardian

Signed:_____
Witness

**FOR OFFICE USE ONLY**

DATE RECEIVED:_____/_____/_____ DATE COPIED: _____/_____/_____ COPIED BY:_____
Other notes:_____

Ok to copy:_____
Dr. Initials