



**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I voluntarily authorize the FiCAREMed named below to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis including x-rays, correspondence and/or medical records including those from my other healthcare providers that the FiCAREMed may hold, by means of mail or fax.

**Health Provider for FiCAREMed to Release Records to:**

Provider: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

**FiCAREMed to Release Records To (choose one):**

Patient will pick up

Health Care Provider listed Above

**FiCAREMed to Release (choose one):**

All medical records

Medical records with the following exception(s)

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. I understand that I have a right to receive a copy of this authorization. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above. This authorization will remain in effect for one year from the date that it is signed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_