RELEASE OF MEDICAL RECORD

I authorize _____
NAME OF PHYSICIAN OR HOSPITAL

_____
ADDRESS

_____
PHONE AND FAX NUMBER

to release my medical records

I understand that I have the right to inspect and review the information to be disclosed and I may revoke this authorization at any time in writing, except to the extent that action has been taken. I also understand that I may specify a date for the expiration of the authorization, but that it shall by Law, without my express revocation expire one year from the date written below.

I direct this authorization expire on _____

Patient Name_____

Date of Birth_____ SS#_____

_____
SIGNATURE

Dear Physician or Hospital,
Please send any records that will help in the future care of the above named patient. Especially helpful would be a clinical summary, any hospital discharge summaries, recent visit notes, x-ray results, recent EKG, labs, consultation notes and medication lists. We sincerely appreciate your effort in providing this information.

PERSONAL PHYSICIAN CARE
ANDREW LAZRIS, M.D.
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