

THCF Medical Clinic

THOMAS O. ORVALD, MD
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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient, or by a person authorized by law to give authorization.

Phone: _____

I authorize: _____ Fax: _____

(Doctor or clinic name)

to release medical information for:

Patient Name: _____ Date of Birth: _____

Patient Telephone Number: _() _____

Area Code

to the office of **Thomas O. Orvald, MD.**

Information will be used on my behalf for the purpose of continuity of patient care relating to the following medical condition(s): _____

By **INITIALING NEXT TO THE Xs BELOW**, I specifically authorize the release of the following records:

**INITIAL
HERE**

- _____ Clinician office chart notes (**most recent two or three visits only**)
- _____ Diagnostic imaging reports (**within the past THREE YEARS only**)
- _____ *HIV/AIDS-related records (**within the past THREE YEARS only**)
- _____ *Mental health information (**within the past THREE YEARS only**)
- _____ *Drug/alcohol information (**within the past THREE YEARS only**)

*Must be initialed to be included with other documentation

**INITIAL
HERE**

PERMISSION TO FAX INFORMATION: YES _____

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. This authorization may be revoked at any time. The only exception is when action has been taken in reliance of the authorization. Unless revoked earlier, this consent will expire 90 days from the date of signing or shall remain in effect for the period reasonable to complete the request.

Date: _____ Signature: _____