AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:_____ DOB/MR #:_____

This authorizes

_____

to release the following Medical information:

[X] ALL MEDICAL INFORMATION

or

[ ] Laboratory Results
[ ] EKG Reports
[ ] Operative Notes
[ ] Other (Specify)_____
[ ] History and Physical
[ ] Billing Statement

The above information is **TO BE RELEASE TO** the following agency, facility, or person:

[ ] Patient

or

Clinic W – David S. Wilson, M.D.
102 Medical Center Drive
Clanton, AL 35045
205-287-3900 / 888-300-4079 FAX

For the purpose(s) of:

[ ] Continued Healthcare
[ ] Legal
[ ] Other (Specify)_____
[ ] Reimbursement

Patient's Signature: *_____Date:_____

Parent/Guardian Signature*_____Date:_____

**Consent will expire in 90 days. Consent can be revoked at any time in writing by the patient unless action has already been taken.

The specified materials have been validated for release:_____
(Staff Signature/Title)

Medical Information released by: _____ Date:_____
(Staff Signature)

* If Applicable