Douglas Sears, M.D., a Professional Corporation

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Release of Medical Records

I hereby authorize the release of information from the medical record of:

Patient Name: ___________________________________ Date of Birth: _______________
Social Security Number: ___________________________ Phone Number: _____________

INFORMATION RELEASE TO: **FROM:**

__________________________________ ________________________________
__________________________________ ________________________________

Please release the following:

____ Problem List ____ X-ray reports
____ Progress Notes ____ EKG reports
____ History & Physical ____ Other Diagnostic Reports (Specify) __________
____ Lab reports ____ Other (Specify) ___________________________

Including information (if applicable) pertaining to:

____ Mental Health ______ Patient Notes _____ Drug/Alcohol ____ HIV/AIDS

Purpose or Need for Disclosures:

____ Continued Patient Care ____ Personal Use
____ Attorney/Legal ____ Insurance Claim/Application
____ Disability Determination ____ Other (Specify)

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I can revoke the consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature: ____________________________________ Date: ______________________

Witness: _________________________________ Relationship to patient: ____________

COMPLETE ONLY IF INFORMATION TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Douglas Sears, M.D., a Professional Corporation. Or Douglas Sears, M.D. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature: ___________________________________ Date: ______________________

Witness: _________________________________ Relationship to patient: _____________