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CONFIDENTIAL FAX

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__Urgent __Time Sensitive __Reply Requested

Date: _____ **Time:** _____

To: _____

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THIS IS A ONE PAGE FAX

Authorization For Release of Medical Information

I herewith authorize:
Dr. or Provider Name: _____
Address: _____
City: _____
State: _____ Zip: _____

To release to Dan F. Bautista M.D., my medical history, lab reports, x-rays and any other material regarding medical consultations and treatment I have received **WITHIN THE PAST 1 YEAR**. My records should be under the following names(s).

_____ _____ _____
Patient's Name Birth Date Social Security Number

Any disclosure of medical record information by the recipient(s) of this information is prohibited except when implicit in the purpose of this disclosure. I hereby waive and release of medical records in accordance with this authorization.

The specific reason for the protected health information to be released is to provide continuity to my medical care and _____.

This authorization shall expire 1 year from request date or until revoked by me in writing which ever comes first.

_____ _____
Patient/Guardian/Patient Representative Signature Date