DUBLIN MEDICAL CENTER

FAMILY MEDICINE

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www.Dublin-Medical.com

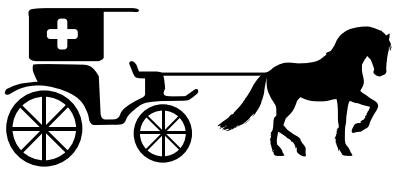
Authorization for Release of Medical Records

Patient Information				
Last Name	First Name		Middle Initial	Previous Name (If applicable)
Mailing Address		Apt #	City	State / Zip Code
Date of Birth	Phone Number		Email Address	

I authorize the below medical records to be disclosed / released.				Please Initial
☐ All Records	☐ Lab / Pathology Results	☐ X-Ray / Radiology Records	☐ Office Notes	☐ Other

**Note: If these records contain any information about drug/alcohol abuse, sexually transmitted disease, or psychiatric issues, you are hereby authorizing disclosure of this information.

Please release my records to:				
Organization Name				
Address		Apt #	City	State / Zip Code
Phone Number	Fax Number		Email Address	



By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

Patient or Representative's Signature

Date