



**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

**Records to be released:**

<input type="checkbox"/> from  <input type="checkbox"/> to	Name: _____	<input type="checkbox"/> to  <input type="checkbox"/> from	<b>Meliora Family Medicine PLLC</b>  <b>Jessica Davis, MD</b>  <b>PO Box 173, Stillwater NY 12170</b>  <b>Fax: 877-664-6116 ( Please call first)</b>
	Address: _____ _____		

**This request and authorization applies to:**

- All records
- Health care information relating to the following treatment, condition or dates:

Please DO NOT release records of the following:  mental health,  drugs/alcohol,  HIV

**Please include the following information:**

- |                                  |   |
|----------------------------------|---|
| Problem List                     | Most Recent Discharge Summary (if any)                |
| Medication List                  | Laboratory Results <b>from the last 12 months</b>     |
| List Of Allergies                | X-Ray /Imaging Reports <b>from the last 12 months</b> |
| Immunization Record              | Consultation Reports <b>from the last 12 months</b>   |
| Most Recent History And Physical | Progress Notes <b>from the last 12 months</b>         |

**This release expires (choose one) : After 1 time / 1 year after the date signed / Never**

I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has already acted in reliance upon this authorization. There is no fee to provide records to another health provider. There will be a fee to provide records to any other party such as an attorney, insurance company, etc.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Guardian Name

\_\_\_\_\_  
Relationship