

Jessica Davis MD

The New Mom's Family Doctor
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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: ___/___/___

Previous Name: _____ Social Security #: ___ - ___ - ____

Records to be released:

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

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 from the last 12 months
List Of Allergies	X-Ray /Imaging Reports from the last 12 months
Immunization Record	Consultation Reports from the last 12 months
Most Recent History And Physical	Progress Notes from the last 12 months

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