



American Family Care
The Right Care. Right Now.

**AUTHORIZATION FOR RELEASE
OF MEDICAL RECORDS**

NAME OF PATIENT: _____

PATIENT DOB: _____ PATIENT SSN: _____

PURPOSE OF RELEASE: _____

NAME AND ADDRESS OF PARTY INFORMATION IS BEING RELEASED TO:

NAME AND ADDRESS OF PARTY INFORMATION IS BEING RELEASED FROM:

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION (TO INCLUDE ALL PHYSICIAN'S NOTES, LAB RESULTS, X-RAY AND DIAGNOSTIC RESULTS AND ANY MENTAL OR SUBSTANCE ABUSE RECORDS) INCLUDING DIAGNOSIS, TREATMENT, PROGNOSIS, ETC., OF THE INJURIES AND/OR ILLNESSES RECEIVED BY THE ABOVE NAME PERSON ON AND SUBSEQUENT TO THE DATE OF THE INJURIES AND/OR ILLNESSES. AUTHORIZATION EXPIRES IN 365 DAYS UNLESS REVOKED IN WRITING.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

WITNESS

DATE