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Authorization and Request to Release Information to Blue Skies Family Medicine, P.A.

Patient Name_____

Address_____

Date of Birth_____Social Security Number_____

I hereby authorize _____
Name of facility, doctor or other provider

Mailing address_____

To Release to Blue Skies Family Medicine

Information to be Released_____
Limitations on date(s) or procedure(s)

If no limitations stated, I further authorize and request that you provide copies thereof with no limitations placed on dates, history of illness, and/or diagnostic information.

The information to be released is confined to the following:

_____Complete Records _____ Physician Orders ___Physician Progress notes

_____Laboratory Data _____X ray reports ___Emergency Room records

_____ECG _____ Treatment Plans

This consent will expire 90 days from the date signed. I understand that I may revoke this authorization at any time, in writing to Blue Skies Family Medicine Record Department. The information authorized for release may include information which may be considered a communicable or venereal disease which may include but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, and HIV/AIDS.

_____
Signature of Patient or Legal Guardian Relationship to Patient Date

_____
Witness Date