General Medical Records Release

Please complete the following information:

Patient Name: _____

Date of Birth:_____/_____/_____

I authorize the custodian of records of

Physician's Name : _____

Physician's Address: _____

_____

to release the following information* (check all applicable):

- ☁ **All records**
- ☁ **Laboratory/pathology records**
- ☁ **X-ray/radiology records**
- ☁ **Billing records**
- ☁ **Pharmacy/prescription records**
- ☁ **Other (describe specifically)**

Note:** **If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis,drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records listed above to:

The Medical Profession, LLC
5301 Reno Corporate Dr.
Reno, NV 89511
775-329-5555
775-827-4613 Fax

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. 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 and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) **Date**

_____

Printed name of patient (or patient's representative and authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor).*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request.