AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION **FROM ATX PRIMARY CARE**

I hereby authorize ATX Primary Care/Robert C. Raley, MD, Aline C. Zeringue, ACNS-BC, Mandy Mishra, ACNS-BC & Sally Reese, APRN, FNP-C, PMHNP – BC to release the information specified to the provider or medical practice listed below:

Patient Name:__________________________________ Patient Date of Birth:_______________

____ ________________________________
Provider/Practice Name Phone #

____
Mailing Address

____
Fax #

Medical Records to be Released: (Check all that apply)

☐History & Physical ☐Progress Notes ☐Lab Results ☐Radiology Reports

☐Immunization Record ☐Consultations ☐Entire Medical Record ☐Other:_______________

Specific Date(s) of services may be requested: ____

I authorize the release of medical records from ATX Primary Care. This authorization expires 90 days from the date of signature.

____ _____________________
Patient Signature/Patient Representative Signature Date

____
Printed Name of Patient/Patient Representative