

Robert C. Raley, MD Aline C. Zeringue, RN, ACNS-BC Amanda Mishra, RN, ACNS-BC Eileen M. Costa, APRN, FNP-C Belinda Read, AGCNS-BC

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 & Eileen M. Costa, FNP-C Belinda Read, AGCNS- BC to release the information specified to the provider or medical practice listed below:

Patient Name: Provider/Practice Name		Patient Date of Birth:		
		Phone #		_
Mailing Address				-
Fax#				
Medical Records to be Relea	ased: (Check all that app	oly)		
☐History & Physical	☐Progress Notes	☐Lab Results	☐Radiology Reports	
☐Immunization Record	Consultations	☐Entire Medical Reco	ord Other:	_
Specific Date(s) of service	es may be requested: _			_
I authorize the release of the date of signature.	of medical records fr	om ATX Primary Care.	. This authorization expires 90 day	ys from
Patient Signature/Patient	Representative Signat	cure	Date	_
Printed Name of Patient/P	atient Representative			