



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

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 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