Authorization for Release of Medical Information

(Your records will be available for pickup or will be sent within 15 business days of this request)

Date of Request: _____ **Date Needed:** _____ (Check One) ☐ **Pick up** ☐ **Mail**

Patient's Name: (Print) _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Patient's Contact Numbers: Home ( ) _____ Work or Cell ( ) _____

☐ I authorize Robert Brei, DDS **to release information to:** _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone # _____ Fax# **Note: Medical Records are faxed in cases of medical necessity**	**OR**	☐ I authorize Robert Brei, DDS **to obtain medical records/information from:** _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone # _____ Fax# **Note: Digital Xrays preferable by email to: office@drbrei.com**

Purpose of this request: (Check) ☐ Healthcare ☐ Insurance ☐ Legal ☐ Personal ☐ Transfer of Care ☐ Other _____

Type of Records Requested: (Check one)

☐ Medical Records related to a specific illness/injury (Specify and give dates of treatment) _____

☐ Copy of all Medical Records allowed by law

☐ Specific Medical Records (Specify) _____

☐ Treatment Summary (includes history physical, lab, xray, pathology, and operative reports)

Authorization Valid for: (Check one) ☐ This request only ☐ One year from date of request

☐ This request and for medical records of future treatment described above until: (Specify Date) _____

Signature of Patient, (Signature of Parent if Patient a Minor, or Legal Representative) _____ Date _____

Relationship to Patient (if requester is not the patient) _____