ABUNDANT HEALTH! FAMILY MEDICINE

Tanya R. Grun, M.D.

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____

Address: _____ City/State/Zip : _____

Patient's phone number: _____

Date of Request: _____ Date Needed: _____

o **I authorize Abundant Health! Family Medicine to release information to:**	OR	o **I authorize Abundant Health! Family Medicine to obtain information from:**
Name of Provider or Facility:		**Name of Provider or Facility:**
Address:		**Address:**
City/State/Zip Code:		**City/State/Zip Code:**
Phone/Fax:		**Phone/Fax:**

Purpose for this request: (Check one)

__ Transfer of care __ Upcoming appointment __ Insurance verification

__ Other _____

Type of records requested: (Check one)

__ Imaging reports __ Recent visit notes __ Laboratory results

__ Other _____

I understand that:

My right to healthcare treatment is not conditioned on this authorization. I may cancel this authorization at anytime by submitting a written request to the office. This request will be valid for one year from the date signed. There may be a charge for the requested records.

Signature of Patient/Parent/Guardian: _____

Date: _____ **Abundant Health! Family Medicine Fax: 830-625-0353**

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