AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Address: _____

This is to authorize the release of medical information regarding the person identified above.

Circle One: TO FROM

☐ **Glen S. Lovelace, M.D.** ☐ **Jennifer L. Hudson, D.O.**

☐ **Angela M. Latta, NPC** ☐ **Kristi Rhodes, CNM** ☐ **Megan Kitterman, CNM**

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Circle One: TO FROM

_____
Name

_____
Address

_____
Phone and Fax Numbers

Information requested:

_____ All _____ Labs/Pathology _____ Procedure/Hospital notes

_____ Clinics notes _____ Other: _____

This consent is valid for one year from the date signed unless revoked in writing with the exception of information released prior to date signed. We cannot condition treatment or eligibility of benefits on whether the authorization is signed and has the potential to be disclosed by the recipient and is no longer protected.

Patient Signature _____

Witness _____

Date _____