GLEN S LOVELACE MD PA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name ______________________ Date of Birth ______________________

Address ______________________ Phone ______________________

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
- ☐ Jill Keely, CNM

200 N 3RD STREET | SUITE 110 | BOISE, IDAHO 83702
Ph: (208) 345-3136 | Fax: (208) 345-0984 | Email: idahostork@gmail.com

Circle One: TO FROM

Name ______________________

Address ______________________

Phone number ______________________ Fax Number ______________________

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 ______________________ Date ______________________

Witness ______________________ Date ______________________