LINDA A. STEELE, DDS

Authorization for Release of Medical Information

Patient name	Patient date of birth	
Patient Address		
City	**State**	**Zip**
Date records requested	**Date records released**	

I, the undersigned, authorize ______________________________

- ❑ To release my medical records from the following doctor and address
- ❑ To obtain my medical records from the following doctor and address.

Physician Name ______________________________

Address ______________________________

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Phone ______________________________

My request for this particular release of medical records includes the following specific records (please include specific time period and/or specific type of record):

Instructions:

The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient signature	Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: The information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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