



Dr. Rosario B. Gonzaga
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Authorization for Release of Protected Health Information

Patient Name: _____ Patient Date of Birth: _____

The person named above has been a patient of:

Name of Medical Provider: _____
Address of Medical Provider: _____
Phone: _____
Fax: _____

The person or parent named above hereby authorizes _____ to release the medical records to the following:

Name of Medical Provider: _____
Address of Medical Provider: _____
Phone: _____
Fax: _____

Scope of Release (please place an X on one)

- Complete medical record
- All information regarding assessment, diagnosis, and treatment of the patient's condition, concern, or disease
- Other (please specify): _____

I understand that this authorization is effective for a period of one year from the signature date unless otherwise specified. I understand I have the right to revoke this authorization at any time by sending a written request to the entity I authorized to release the information. By signing this authorization, you are agreeing to the use and disclosure of certain protected health information to the recipient listed above.

Authorization:

Name of Authorized Representative (Print): _____

Signature: _____	Date: _____	Initial: _____
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If not signed by the patient because the patient is a minor, please indicate the relationship of the person authorizing this form: _____

Reason for Transfer: _____