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Patient Name: _____
Date of Birth: _____
Address: ____ _____
Phone Number: _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above named person be forwarded:

From: Physician/Institution: _____
Address: _____
City _____ State ____ zip_____

To: Person/Physician/ Institution: _____
Address: _____
City_____ State ____ zip_____

Purpose or need for information_____

Records for the period (dates) from _____ to_____

Signature of Legal Guardian _____Date: _____
Relationship to Patient _____

Signature of Patient_____Date: _____

REDISCLOSURE: Notice is hereby given to patient or legal representative signing this Authorization that Thomas J. Weigel, MD, SC cannot guarantee that the Recipient receiving the requested information will not redisclosure any or all of it to others. Notice is hereby given to Recipient that law prohibits the redisclosure for any health information. I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical records contact person at this site except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing.