# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization covers requests by Aurora Family Medicine Center, PC (AFMC) for medical records FROM previous care givers OR patient/guardian requests to SEND copies of AFMC's medical records to another medical care provider.

**Release to:**_____ **From:**_____

_____ _____

_____ _____

_____ _____

Patient's Name: _____

Date of Birth:_____

Patient's Current Address:_____

Patient's Phone Number:_____

Please release my/my child's medical records as described below:

____All my medical record in your possession

____All records concerning my treatment for_____

_____

____All records concerning treatment provided between _____and_____

**AUTHORIZATION:** I make this request willingly. The information is true as far as I know. I know that I may take away this permission anytime, except when my medical records have already been sent. This permission will automatically end in 3 months from the date below unless I say otherwise.

____I authorize you to send my/my child's record by fax (under special circumstances) with the understanding they cannot be guaranteed to remain confidential.

A copy of this authorization, with my signature, is valid as the original

_____ _____

Date Signature of patient or authorized representative

_____ _____

Date Witness

**PLEASE NOTE THE FOLLOWING AFMC POLICY:**

*There is **no charge** to send copies of the record to a specialty physician we have requested you to see.

*There is a **$15.00 Prepayment charges** for request to **send copies** of you/your child's records to another physician or facility.