Authorization to Release Health Information

Patient Name ______________________ DOB _____ / _____ / _____

Patient Phone ______________________

I hereby authorize the release and disclosure of medical information for the above-named patient to Mason-Dixon Mobile Medicine for the purposes of continuity of care, chronic care management, or transitional care management purposes.

Unless otherwise specified, please release the following information (as applicable):

a. Office Medical Records (prior 2 years)
b. Hospital Records (prior 2 years)
    - admission H&P
    - discharge summary
    - specialty consultation reports
c. Imaging Reports (prior 5 years)
d. Laboratory Results (prior 18 months)
e. Specialty Diagnostics Testing Reports (prior 5 years)
f. Home Health Services (prior 2 years)

__________________________ ______________
Patient/Guardian Signature Date

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Guardian Name (as applicable)

This release form shall expire two (2) years from the date indicated above.