Donni Fleischaker
PRIMARY CARE & PEDIATRICS

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Authorization to Release Medical Records

Use this form to request that records be sent to or from our office.

PATIENT FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____

DIRECTION OF RELEASE

☐ Send my records FROM the provider below TO Donni Fleischaker ☐ Send my records FROM Donni Fleischaker TO the party below

NAME OF OTHER PROVIDER / FACILITY / PERSON _____

ADDRESS _____ PHONE / FAX _____

RECORDS REQUESTED

☐ Complete record ☐ Office visit notes ☐ Lab results
☐ Imaging reports ☐ Immunization record ☐ Medication list

DATE RANGE OF RECORDS _____ PURPOSE OF REQUEST _____

I authorize the release of the information indicated above. I understand this authorization is voluntary, that I may revoke it in writing at any time except where action has already been taken, and that the information may include records related to sensitive conditions unless I note otherwise here: _____. Unless revoked, this authorization expires one year from the date signed.

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE _____ RELATIONSHIP (IF NOT PATIENT) _____ DATE _____