Trace Medical Clinic
Consent for Release of Information / Medical Records

I hereby authorize Trace Medical Clinic to disclose the following information from the health records of:

Patient Name_____ Date of Birth_____

Address_____ Social Security #_____

Covering the period(s) of health care from_____ to _____.
Date Date

Information to be released:

□ Complete Medical Record(s)
□ Progress Notes
□ Laboratory Test Results
□ Other (please specify) _____
□ History and Physical Examination
□ Consultation Reports
□ X-ray Reports

This information will be disclosed to _____,

mailing address _____,

for the purpose of _____.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Trace Medical Clinic, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____	_____	_____
Printed Patient Name	Signature of Patient	Date
_____	_____	_____
Printed Name of Guardian	Signature of Guardian (if patient is minor)	Date
_____	_____	_____
Printed Name of Witness	Signature of Witness	Date