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*****AUTHORIZATION TO OBTAIN HEALTH INFORMATION*****

Patient Name: ____________________________ Date of Birth: _____________

Last 4 of SS#: ______________________ Phone: _______________________

Address:

____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

I, _____________________________(print name) do hereby authorize ___________________________ (clinician/entity) to release the following information:

Complete Medical Record   Biopsy Report(s)   Lab Report(s)

Consultation Reports   Hospital Progress Notes   Hospital Discharge Notes

Operative Reports   Other:_____________________________________

Dates of Service: ____

Release information to:

Katrina A. Bramstedt, PhD
PO Box 1620
Sausalito, CA 94966
Fax: (415) 332-0102
txbioethics@yahoo.com

I understand that I may be required to pay a fee for copying these medical records.

I have read the above information and I am the patient or acting on behalf of the patient.

______________________________ ___________________________________
Signature of Patient   Date

______________________________ ___________________________________
Signature of Witness   Date

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