

ROBERT J. SANIUK, MD
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AUTHORIZATION TO RELEASE AND/OR OBTAIN MEDICAL RECORDS

Patient name: _____ DOB: _____

Patient name: _____ DOB: _____

Patient name: _____ DOB: _____

I authorize information to be obtained from:

Bellevue Family Practice

-or-

Doctor/Hospital name: _____

Street: _____

City, State, Zip: _____

Phone: _____

Fax: _____

And/Or:

Please release my records to:

Bellevue Family Practice

-or-

Doctor/Hospital name: _____

Street: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Information to be obtained or released to include:

- Complete Medical Record
- Immunization Record
- Dates _____ to _____
- Other

I authorize the release of

the indicated sensitive records

also (patient to initial)

Mental Health Records... _____

HIV or AIDS..... _____

Chemical Dependency..... _____

This information is being disclosed for the purpose of:

If no purpose is stated, the purpose of the disclosure will be "at the request of the individual." This statement of consent can be revoked at any time before the disclosure of the information, and expires in any event, one year after it's signed. A photocopy of this authorization shall be valid as the original.

Signature of patient/guardian: _____ Date: _____