MARY KELLY GREEN, MD, PLLC

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Authorization to Release Medical Information

Patient Name:____Date of Birth:__________________

Address:_______________________________________City, State, Zip:________________________

Release Medical Records From:____

____

____

Phone #_____________________Fax #_________________________

Information to be released:______ Complete Medical Records:_____ Other:_____________________

Purpose for Disclosure – (Choose Reason)

_____ Personal Copy - $25 Charge

_____ Further Medical Care – Sent Directly to Physician/Doctor

I agree that any information regarding drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/Aids, genetic testing may be released.

_____Yes (Initials) _____No (Initials)

I agree that any medical billing record(s) containing information in reference to drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/Aids, genetic testing may be released.

_____Yes (Initials) _____No (Initials)

I further authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to revoke this request. Additionally, I hold harmless Mary Kelly Green, M.D. PLLC, its agents and employees from any recourse due to any loss, claims for injury or damage, costs, expenses, neglect, or injury or damage caused by any unintentional acts or omissions.

Signature of Patient:____Date:________________

Authorized Signature:_________________________Relationship:______________Date:___________

We can accept 10 pages or less via fax. If you have more than 10 pages to send, please mail to address above. Thank you.