The Rosa Health Center

10 NORTH FRONT ST GEORGETOWN DE 19947
T: (302)858-4381 F: (302)858-4416

RELEASE OF RECORDS

DATE:_____

PATIENT NAME:_____D.O.B:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

PHYSICIAN/FACILTY RECORDS TO BE RELEASED FROM:

NAME:_____

ADDRESS:_____

TELEPHONE:_____

FAX:_____

PHYSICIAN/FACILITY RECORDS RELEASED TO:

NAME:_____

ADDRESS:_____

TELEPHONE:_____

FAX:_____

INFORMATION TO BE RELEASED:_____

REASON FOR REQUEST:_____

I,_____AUTHORIZE THE ROSA HEALTH CENTER TO RELEASE/OBTAIN INFORMATION RELEATED TO MY MEDICAL CARE.

I AUTHORIZE THE INFORMATION SPECIFIED IN THIS RELEASE TO BE DISCLOSED ACCORDINGLY. THIS RELEASE MAY BE REVOKED AT ANY TIME WITH WRITTEN NOTIFICATION TO THE LISTED FACILITY OR PHYSICIAN. THE CONSENT TO RELEASE/OBTAIN THE SPECIFIED INFORMATION SHALL EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE UNLESS OTHERWISE NOTED ON THIS FORM. A PHOTOCOPY OF THIS CONSENT CONSTITUTES A VALID AUTORIZATION.

PATIENT/GUARDIAN SIGNATURE:_____DATE:_____

WITNESS SIGNATURE:_____DATE:_____