Tuscaloosa Integrative Family Medicine

Caroline Day, M.D.

Authorization for Release of Medical Records

Patient Name: ____

Patient DOB: ____________________ Patient SSN: ____________________

Records Requested: ____

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Please release my records FROM: ____

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Please release my records TO: ____

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I hereby authorize the release of any and all medical information (to include all physician's notes, lab results, X-rays, and diagnostic results and any mental or substance abuse records) including diagnosis, treatment, prognosis, etc., of the injuries and/or illnesses received by the above named person on and subsequent to the date of the injuries and/or illnesses. Authorization expires in 365 days unless revoked in writing prior to that.

Signature of patient or legal guardian: ____

Date: ________/________/________

Witness Signature: ____

Date: ________/________/________