FALL CREEK INTERNAL MEDICINE, LLP
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
FOR PERSONAL USE ONLY

_____ _____

Patient Full Name (Please Print) Date of Birth (mo/day/yr)

_____ _____

Street Address Phone Number

I herby authorize **FALL CREEK INTERNAL MEDICINE** to release the following records: (**Initial** the appropriate spaces**)**

_____ Laboratory Reports _____ Radiology Report

_____ Other:

_____

Information Release to: Self-Personal

Purpose of Disclosure: Personal

I understand the information used or disclosed is for **my personal use** and understand and accept the statements contained in this authorization. **I also understand if I wish to request to have any of my medical records to be released to another physician or entity, a different Medical Records release has to be obtained, reviewed, and signed.** This authorization may be revoked at any time **unless revoked early this authorization will expire one year from the date of original signing.**

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Doctor or M.A. Signature of Approval **Date**