Optimum Health/David Miloy MD, PA

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Medical Records Request

Authorization For Release of Confidential Medical Information

PATIENT NAME: _____ BIRTHDATE: _____
ADDRESS: _____ TELEPHONE: _____

I hereby authorize the release of medical records and/or information regarding my medical situation, and if applicable, all specific lab test (including HIV infections) related to my medical condition.

_____ Complete Medical Records
_____ Hospital Records
_____ Laboratory Test Results
_____ Other (Specify)

_____ X-Ray Reports only
_____ Consultation Reports
_____ Progress Notes

I hereby authorize this office:

____ to RECEIVE the above information from:
____ to TRANSMIT the above information to:

_____

_____

_____

_____

I understand I may withdraw this authorization at any time but must do so in writing. Above information may only be shared with another person per my written release of approval.

_____

Patient Signature Date

_____

Witness Date