Rosedale INFECTIOUS DISEASES

Date:_____

Authorization to Release Medical Records

Patient Name **DOB** **Phone**

Address **City** **State** **Zip**

_____ **Please send records to Rosedale ID** **Dates:**_____

_____ **Please send records to my insurance provider** **Dates:**_____

_____ **Please send me copies (fees apply**)** **Dates:**_____

_____ **Please send to other Physicians** **Dates:**_____

_____ **Please send records to Attorney/Law office** **Dates:**_____

_____ **Other**_____ **Dates:**_____

I authorize Rosedale to _____ **Obtain my records** _____ **Release**
_____ **From** _____ **To**

Name of Physician/Practice/Insurance/Attorney

Address **City** **State** **Zip**

Telephone **Fax**

X **Patient Signature** **Date**

I understand that this authorization is confidential, except for action already taken in good faith and may be voided by either Rosedale ID or the patient at any time for any reason. Unless otherwise indicated, this release is valid for one year from the date of signature. Please note: This information contained in this document is privileged and confidential. It is for use of the named recipient only. Rosedale ID, its officers and employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

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