



I, \_\_\_\_\_ authorize and request the office of

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to release my medical records to

- |   |   |
|---|---|
| <input type="checkbox"/> Megan A. Isaacs, M.D.    | <input type="checkbox"/> Lindsey J. Knepp, FNP-C  |
| <input type="checkbox"/> Jennifer M. Lueken, M.D. | <input type="checkbox"/> Tara M. Knight, FNP-C    |
| <input type="checkbox"/> Farah R. Snyder, M.D.    | <input type="checkbox"/> Bethany J. Lubenow, PA-C |
| <input type="checkbox"/> Kristin S. Werne, M.D.   | <input type="checkbox"/> Holly J. Zehr, FNP-C     |

\_\_\_ **Records are needed for plan of care (URGENT)** \_\_\_ **Records are needed for continuity of care**

Records to be released and the dates treatment occurred:

[ ] All records: \_\_\_\_\_

[ ] Lab Work: \_\_\_\_\_

[ ] Pathology report: \_\_\_\_\_

[ ] Radiology report: \_\_\_\_\_

[ ] Operative report: \_\_\_\_\_

[ ] Other: \_\_\_\_\_

Purpose for release: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Address \_\_\_\_\_

Patient Phone \_\_\_\_\_ SSN \_\_\_\_\_

This information is to be used for the purpose of further evaluation and treatment or for communication with other parties who are specifically named above. I understand that in order to obtain or release information, my consent is necessary. This consent is effective for 60 days from the date of signature. This consent may be revoked at any time by written or oral request of the person giving the consent.

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_