

# PONDEROSA HEART

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## MEDICAL RECORDS RELEASE AUTHORIZATION

Patient's Full Name: _____	PATIENT INFORMATION
Date of Birth: _____	
Street Address: _____	
City: _____ State: _____ Zip Code: _____	
Primary Phone Number: _____	
E-Mail Address: _____	

IF RELEASING TO AN INDIVIDUAL		AUTHORIZATION RECIPIENT INFORMATION
Full Name: _____		
Relationship to Patient: _____		
Street Address: _____		
City: _____ State: _____ Zip Code: _____		
Phone Number: _____		

IF RELEASING TO A HEALTHCARE PROVIDER		AUTHORIZATION RECIPIENT INFORMATION
Office Name: _____		
Provider Name: _____		
Office Address: _____		
City: _____ State: _____ Zip Code: _____		
Phone Number: _____ Fax Number: _____		

IF RELEASING TO A COMPANY/BUSINESS (E.G. LEGAL OFFICE)		AUTHORIZATION RECIPIENT INFORMATION
Company Name: _____		
Authorized Representative: _____		
Company Address: _____		
City: _____ State: _____ Zip Code: _____		
Phone Number: _____ Fax Number: _____		

<input type="checkbox"/> Complete Medical Records	INFORMATION TO BE RELEASED
<input type="checkbox"/> Specific Date Range From: _____ To: _____	
<input type="checkbox"/> Specific Information (describe): _____	
_____	

<input type="checkbox"/> Transfer to New Healthcare Provider	PURPOSE OF RELEASE
<input type="checkbox"/> Legal Proceedings	
<input type="checkbox"/> Caregiver/Family Member	
<input type="checkbox"/> Other: _____	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_