Medical Records Release Authorization

Name of Patient ____ **DOB** ________________________

I, the undersigned, authorize the release of the information specified below from the medical record(s) of the above named patient.

Patient information is needed for continuing medical care from (please complete):

Doctor/Provider/Practice Name: ____

Address:____

Phone:___________________________________Fax: _______________________________________

Information to be released:
Physician / provider visits (initial consult and follow up), office notes and lab reports for dates
______________________ to ______________________.

The above information may be released to:

aNu Aesthetics & Optimal Wellness
10090 NW Prairie View Rd
(or 547 Grand Blvd)
Kansas City, MO 64153
Phone: 816-359-3310
Fax: 816-296-7694

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken is reliant upon the authorization.

The authorization will expire (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Patient Signature ____ **Date** __________________

Printed name of patient ____