GALATIANS FOUNDATION

RELEASE OF INFORMATION - REQUEST TO SEND RECORDS **FROM** OUR PRACTICE

PATIENT INFORMATION:	Name:	
	Address:	
	Phone:	Date of Birth:

SENDING RECORDS FROM:	☐ **Galatians Community Health** ☐ **City of Oaks Wellness**

PURPOSE:

Why am I requesting my records?

- ☐ Continued Patient Care/Patient Treatment
- ☐ Attorney / Legal
- ☐ Disability / Workers Comp
- ☐ Other_____
- ☐ Transfer of Care
- ☐ Change of Insurance
- ☐ Personal

SENDING RECORDS TO:

Provider / Facility Name:	
Address:	
Phone:	**Fax:**

I consent and authorize the above named Provider / Facility to release copies of my medical records as follows:

- ☐ ALL of my medical records
- ☐ ONLY send records from (Date) _____/_____/_____ to (Date) _____/_____/_____
- ☐ Only send specified records as listed below::

_____

_____

I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. This consent will automatically expire after 90 days from the date on which it is signed.

SIGNATURE: *(Signature of Patient, Parent, Legal Guardian)*	***PRINT NAME:***	***DATE:***
	Signature:	

dba City of Oaks Wellness

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dba Galatians Community Health

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