

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

<b>PATIENT INFORMATION:</b>	Name: _____		
	Address: _____		
	Phone: _____	Date of Birth: _____	

<b>SENDING RECORDS FROM:</b>	<input type="checkbox"/> <b>Galatians Community Health</b>	<input type="checkbox"/> <b>City of Oaks Wellness</b>
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<b>PURPOSE:</b>	<i>Why am I requesting my records?</i>	
	<input type="checkbox"/> Continued Patient Care/Patient Treatment	<input type="checkbox"/> Transfer of Care
	<input type="checkbox"/> Attorney / Legal	<input type="checkbox"/> Change of Insurance
	<input type="checkbox"/> Disability / Workers Comp	<input type="checkbox"/> Personal
	<input type="checkbox"/> Other _____	

<b>SENDING RECORDS TO:</b>	<b>Provider / Facility Name:</b> _____		
	<b>Address:</b> _____		
	<b>Phone:</b> _____	<b>Fax:</b> _____	
	<b><i>I consent and authorize the above named Provider / Facility to release copies of my medical records as follows:</i></b>		
	<input type="checkbox"/> ALL of my medical records <input type="checkbox"/> ONLY send records from (Date) ____/____/____ to (Date) ____/____/____ <input type="checkbox"/> 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.

<b>SIGNATURE:</b> <i>(Signature of Patient, Parent, Legal Guardian)</i>	<b>PRINT NAME:</b> _____	<b>DATE:</b> _____
	<i>Signature:</i> _____	