ARFINN MED
for medical professionals

Medical Release

Patient Information

Patient Name *

Patient Email *

Mobile Phone

Date of Birth (DOB) *

Sex *

Address

City

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State

Zipcode

Name of Physician(s) to request records from

Physician Name

Physician's Phone

Physician's Fax

Information to be disclosed: I authorize the release of the following health information:

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me. *

- [x] **I CONSENT**

I understand this consent is voluntary and that I may revoke this authorization at any time by providing written notice to the above named party. This consent will remain in effect no more than ninety (90) days from the date I signed this consent When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected. *

- [x] **I CONSENT**

I request and authorize to release healthcare information of the patient named above to: *

- [x] **I CONSENT**

Physician's Name

Physician's Contact Information

Signature *

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