ConnellyCare, PLLC

RECORDS RELEASE

Patient Information

Last Name: **First Name:** **Middle:**

Street/PO Box: **City:** **State:** **Zip:**

DOB: / / **SSN:** _____/___/_____ **Phone:**

EMAIL:

I hereby authorize ConnellyCare to release a copy of my medical to my new provider listed below.

Physician: **Email:**	**Telephone Number**
Address	**Fax Number**
City	**Zip**

Medical records include all confidential HIV/AIDS, STD's, alcohol, or drug related information, including mental health diagnoses and treatments, as well as operative notes and delivery reports.

This consent will expire sixty (60) days after the date signed below. I may revoke this authorization at any time providing I notify ConnellyCare in writing. I understand that any release which was made prior to the revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a copy of this authorization is considered acceptable in lieu of the original. I hereby release CONNELLYCARE FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

Patient Signature **Date**

Legally Authorized Representative/Relationship