Joseph Pflanzer, M.D.
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Patient's Authorization for Release of Medical Records

I give my authorization to use or disclose my protected health information. I give this authorization voluntarily.

Patient Name: _____
Patient Address: _____

_____
Phone #: _____
( ) Please release medical records to the following: _____

_____
( ) Please release medical records from the following:(please mail records to Dr. Pflanzler's office) _____

_____

Please check which information you are authorizing to be released or disclosed:
( ) Office Notes ( ) Allergy Treatment Records ( ) Lab Work/X-Ray results
( ) Testing Results ( ) Allergy Extract Formula ( ) Other _____

Indicate the reason for your request for records:
( ) 2nd Opinion
( ) Referral from Physician
( ) Moving
( ) Employer changing insurance to HMO/PPO Plan in which we are not affiliated
( ) Insurance has Requested
( ) Other _____

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people/organizations named in this form. If authorized representative, please print name and indicate relationship to the patient.

Signature(Patient or Parent): _____ Date: _____

Please Print Name Here(Parent/Guardian): _____