



**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

I hereby authorize Infusion for Health, Inc. to release information from the medical record of:

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Release To:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

**Release the Following Records:**

\_\_\_\_\_ All Records                      \_\_\_\_\_ Clinic/Chart Notes                      \_\_\_\_\_ Medication Records  
\_\_\_\_\_ Lab Results                      \_\_\_\_\_ Other: \_\_\_\_\_

**For Dates of Service:** \_\_\_\_\_

**Delivery Method:**

- USPS Mailing Address: \_\_\_\_\_
- Secure E-mail: \_\_\_\_\_
- Fax (no personal fax permitted): \_\_\_\_\_

**Records Purpose or Need for Disclosure:**

\_\_\_\_\_ Continued patient care                      \_\_\_\_\_ Personal Use                      \_\_\_\_\_ Disability determination  
\_\_\_\_\_ Insurance claim/application                      \_\_\_\_\_ Other: \_\_\_\_\_

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent expires 90 days after the date of my signature unless otherwise specified.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient**

**\*\*PLEASE EMAIL COMPLETED FORM TO: [MedicalRecordsRequest@infusionforhealth.com](mailto:MedicalRecordsRequest@infusionforhealth.com) or fax to (888) 377-0160. Please send any inquiries to [MedicalRecordsRequest@infusionforhealth.com](mailto:MedicalRecordsRequest@infusionforhealth.com). Thank you!**