INFUSION
FOR HEALTH

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:
- o   USPS Mailing Address: _____
- o   Secure E-mail: _____
- o   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 **or fax to
(888) 377-0160. Please send any inquiries to MedicalRecordsRequest@infusionforhealth.com. **Thank you!**