

CENTRAL INTERNAL MEDICINE, PA

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified

from:

Central Internal Medicine, PA

to:

Provider Name	Patient Name
Provider Address	Patient SSN
Provider Fax Number	Patient Date of Birth

RECORDS AUTHORIZED TO BE RELEASED

- Medical records for the past 2 years (including mental health notes) Other (please specify)

This authorization will remain in effect until rescinded by the patient or authorized representative. I understand that I can revoke this authorization at any time by writing to the health care provider, but revoking this authorization will not affect disclosures made prior to the time that the revocation is received.

Patient or Representative

Date

Name of Representative (please print)

Relationship to Patient