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Mai N. Dyer, M.D.
Jennifer A. Winkler, CNM

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

Patient's Full Name: _____ Phone: _____

Street Address: _____ SSN#: _____

City/State/Zip: _____ Date of Birth: _____

Request Information From:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City/State/Zip

_____
Phone / Fax

Release Information To:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City/State/Zip

_____
Phone / Fax

Authorize Release of Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Yes___ No___

Information Needed For: Attorney_____ Insurance Company_____ Self_____ Other_____

Is this also a transfer of your medical care? Yes_____ No_____

Records to be: **mailed _____** **faxed to:_____**

picked up _____ **emailed to: _____**
(please print legibly)

Complete Record _____

Partial Record _____
(Indicate info needed and date range…for example, MRI reports 2006, Op Note from 06-13-07…etc.)

Signature: _____ Witness: _____ Date: _____

Please allow at least 7-10 business days for your request to be completed. Charges may apply.
Records are transferred to other physicians as a courtesy; charges will apply when sent directly to patient.
This authorization expires 90 days from date signed.