Release of Medical Record Authorization

Patient's Name	Date of Birth:
Previous Name (if any):	
I request and authorize Zaparackas a	and Knepper, LTD., to release the records for the patient
indicated above. Please release records to the following organization, or person:	
Name:	
Address:	Suite #
City/State:	
Contact Numbers: Home:	Cell:
Type of records requested: (char request):	ges for copies of records may be associated with your
All Health care information	
Records pertaining to specifi	c treatment of condition:
	including treatment and diagnosis of mental illness, drug
and/or alcohol abuse, sexually trans	smitted infections and diseases including HIV/AIDS.
Purpose of release of medical information	on: Continuing Care Personal Use Other:
the following fees: \$25.99 handling fee p \$0.65 per page for pages 26-50; \$0.32 per this authorization at any time, for any resunderstand that a revocation is not effect use or disclosure of the health information insurance coverage and in the insurer has used or disclosed pursuant to this authorization. I also understand to organization or individual. My signature patient health information to the above	
Signature of patient or responsible party	r:
Printed name:	
Date:	
THIS AUTHORIZTION EXPIRES 120 DA For Office Use Only: Received (date)	
Completed(date)(staff initials) Physician