Authorization for Release of Medical Information

Name: _____

Date of Birth: _____

Address: _____
City: _____
State: _____
Zip: _____
Social Security Number: _____

Date of Request: _____

Medical Records Request (check all that apply):

- ☐ ALL medical records for the past 2 years (including progress notes and lab results)
- ☐ ALL medical records
- ☐ Lab results
- ☐ Imaging results
- ☐ Procedure notes
- ☐ Progress notes

I authorize Revive Medical Spa to receive my medical records from:

Facility / Provider Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Phone #: _____ Fax #: _____

By signing my name below I acknowledge and agree with the content of this document and with the release of information.

Signature: _____

Name (Print): _____

Date: _____

PLEASE FAX RECORDS TO REVIVE MEDICAL SPA Fax # (907) 531-7365

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