MIDWAY SPECIALTY CARE CENTER

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Authorization for Disclosure of Protected Health Information

I hereby request and authorize release copies of my medical records to Midway Specialty Care Center, Inc.

Records can be sent to the address above.

I understand that my medical records may contain copies of information received from another health care facility or doctor. I also authorized the release of the following to Midway Specialty Care Center, Inc.

Type of information to be disclosed: (Please check all that apply)

□Entire Medical Record

□ Consultation

□ Dental Records

□ Office Chart Notes

□ Radiology Reports

□ Billing Statements

□ Pathology Reports

□ Emergency Department Reports

□ All Hospital Records

□ Laboratory Reports

□ Other: _____

In addition, I authorize and I am aware that this information may include health information relating to (**INITIAL** if applicable):

_____HIV/AIDS Infection _____Substance Abuse (alcohol/drugs)

_____ Genetic Testing _____ Mental Health

Printed Name: _____ DOB: _____

□ Self or Relationship to Patient: _____Date: _____

Signature: _____ Last 4 digits of Social: _____

This request is set to expire on: _____