Authorization to Release Medical Information

I authorize ____ to use and disclose a copy of
(Name of Clinic Disclosing Information)
the specific health information described below regarding:

Patient Name	Date of Birth	Phone Number

Information to be released:

- ☐ All Hospital Records (including nursing records and progress notes)
- ☐ Diagnostic Imaging Reports
- ☐ Billing Statements
- ☐ Laboratory Reports
- ☐ Clinician Office Chart Notes
- ☐ Emergency/Urgent Care Records
- ☐ All Medical Records
- ☐ Pathology Reports
- ☐ Other ________________________________

Please disclose by ______________________________.
(Date)

Records are to be sent to Kristin Andrs, NP 804-733-3333 (office) / 855-586-3257 (fax) for the purpose of medical review.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Andrs Wellness Consulting, LLC and state that you are revoking the authorization.

I have read this Authorization and I understand it. Unless revoked, this authorization expires 365 days from the date signed.

____ ______________________
(Signature of Patient or person authorized by law) (Date)

Description of Representative's Authority: ____