arthritis health

Patient Name:_____ DOB: _____

I authorize: _____

To release a copy of my medical records to: ☐ Debra Michel, MD

☐ Paige Leykam, NP-C

For the purpose of: _____

Please disclose medical records from (date)_____to_____

Including: Lab X-Ray Office Notes H&P

If applicable, the undersigned further authorizes his/her doctor to disclose a copy of records pertaining to:

Yes☐ No☐ 1) Testing and/or treatment for AIDS and AIDS related diseases
Yes☐ No☐ 2) Treatment of psychiatric illness
Yes☐ No☐ 3) Treatment for drug and or alcohol abuse

Signature of Patient/Guardian_____ Date _____

Address _____

City_____ State_____ Zip _____

Expiration of this release of authorization is 3 months from the above signed date.
Limit faxes to 20 pages unless STAT. Please mail if in excess of 20 pages

PLEASE RETURN THIS REQUEST WITH PATIENT RECORDS

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www.arthritishealth.net