AUTHORIZATION TO RELEASE MEDICAL INFORMATION
PLEASE PRINT CLEARLY

Patient's Name_____

Address_____ Town_____

State_____ Zip_____ Home Phone_____

Birthdate_____

I Authorize Kevin P. McGrath, M.D. to release medical information from my medical records to:
Name of Doctor/ Hospital/ Attorney_____

Address_____

Town_____ State_____ Zip_____

For the purpose of Review/Examination, I further authorize you to provide such copies thereof as may be requested, the foregoing is subject to such limitation as indicated below: (Initial on Applicable Line(s) Below)

_____ Entire Record

_____ Specific Information_____

_____ Old Records from Previous Physician_____

I give special permission to release any information regarding:

____ Substance Abuse ____ Psychiatric/Mental Health Information ____ HIV Information

Reason for Request_____
This Authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Patient/ Guardian Date

_____ _____
Witness Date

FOR OFFICE USE ONLY

Received_____ Completed By_____ Date_____

Total Pages_____ Amount Billed $_____ Postage $_____ Amount Due$ _____