



KyreneInternalMedicine

Caring for Teens, Adults & Seniors

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Authorization To Release Medical Records TO Kyrene Internal Medicine

This information is from confidential records which are protected by State Law that prohibits further disclosure of the information without the specific written consent of the person to whom it pertains to, as otherwise permitted by law.

PATIENT INFORMATION

Last Name	First Name	Middle Initial		
Phone Number		Date of Birth		
Address		City	State	Zip

INFORMATION TO BE RELEASED

All records Selected records only
 Mental Health
 HIV Testing
 Alcohol/Substance Abuse

PURPOSE / FOR INFORMATION

Changing Physicians
 Further Treatment
 Insurance Reasons
 Other Reason: _____

COPIES TO BE RELEASED FROM

Doctor's Name		Office Name		
Address				
City		State		Zip
Phone			Fax	
Signature of Patient or Legally Authorized Representative				Date

Confidentiality Note:

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