

AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL INFORMATION

Date

Patient Name

Date of Birth

Address

City, State, Zip

I, _____, hereby authorize **The Manette Clinic, PSC** to
 receive or disclose information from the above named patient's medical records,
including laboratory results, radiologic testing results, medications, hospitalization
information, office notes, and treatment plans for the purposes of _____
_____. I understand that this authorization will expire in 30 days,
and that it may be revoked at any time in writing. I further understand that continued
treatment of the above named patient is not contingent upon receipt of this information.
Also, the information used or disclosed pursuant to this authorization may be subject to
redisclosure by the recipient and no longer protected by the HIPPA privacy rule.

Please send the requested information to:

Specific records being requested:

Name

Address

City, State, Zip

Fax

Signature of Patient or Legal Guardian

Relationship