RECORDS RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip:_____

*****I hereby authorize the release of my Medical Information to:**

Affinity Health Group Provider(s) _____

_____

From: _____

Please fax the following from my Medical Record to Affinity Health Group at (318)807-1039.

- ☐ Bone Density
- ☐ CT Scan
- ☐ Lab
- ☐ Mammogram
- ☐ Office Visits / Consults
- ☐ Pathology
- ☐ Xray
- ☐ Other _____

Notes:

_____

****By signing below I agree to the release of information to the above named provider.**

Patient/Guardian Signature: _____ Date: _____