COMPREHENSIVE PRIMARY CARE
FAMILY MEDICINE CLINIC

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Authorization to Receive Medical Records / Information

I authorize the release of my medical records by the organization or physician listed below:

From:	Physician's Name:	
	Physician's Address:	
	Physician's Phone #:	Fax # of Physician:
	Reason for Record's Release:	
To:	Obinna Uzowulu, M.D. Comprehensive Primary Care Group	

Please send Medical Records to the contact information provided above.

Patient's Name:			DOB:
	Address:		
	City:	State:	Zip Code:
	Phone #:		

The type and amount of information to be disclosed is initialed as follows (specify dates where appropriate):

- ☐ Imaging/X-Ray/Labs _____
- ☐ Most Recent Records, last # of visits 1 2 3 4 5 (circle one)
- ☐ Entire Medical Records

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it.

I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company.

I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____
Patients Name Date

_____ _____
Patient's Parent/ Guardian/ Representative Relationship to Patient