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Medical Records Release

Patient Name: _____

DOB: _____ SSN: _____

I hereby authorize: _____

To release my medical records to:

Dr. Richard B. Johnson **Mistie Kocurek, FNP**

Most recent progress note and labs Most recent imaging Pap Smear

Most recent Colonoscopy Entire Record Other: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that, in any even this authorization expires automatically as described below.

This authorization will expire sixty (60) days from the date of my signature.

Signature: _____ Date: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____