Haydee Docasar, M.D.

www.haydeedocasarmd.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ DOB: _____ SSN: _____

I hereby authorize the staff, physicians and/ or agents in behalf of
HAYDEE DOCASAR, M.D.
To receive confidential medical information regarding the following:

_Obstetrical Records

_Gynecologic Records

_Entire Record

_Laboratory results from (date) _____ Name of lab test (s): _____

_X-ray and Diagnostic Report from (date) _____ Type of X-ray_____

_Other: _____

RELEASE TO / FROM

Previous Doctor and/ or name of Medical Facility: _____

Phone: (____)_____Fax: (___)_____ Email: _____

Signature: _____ Date: _____

PLEASE FAX REQUESTED RECORDS TO: 1-855-898-8685

If you are requesting your records to be released to another individual or organization outside of our office please give the following information:

RELEASE TO INDIVIDUAL

Name of individual to release your information to : _____Relation: _____
Address: _____ City, State. Zip: _____
Phone: _____ Fax: _____ Email: _____

REASON FOR REQUEST: (PLEASE CHECK ONE)

_Transferring care to another doctor _INSURANCE _PERSONAL _ATTORNEY

Signature of Patient/ Guardian: _____ **Date**: _____

There will be a charge of $0.60 per page when releasing records directly to the patient or outside party. Please allow ten 10 business days for processing.

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