HealthAlways "Solutions for Life"

Ray Psonak D.O.
207-657-4325
Fax: 757-315-8052

Release of Health Records Patient Authorization

Please type or print clearly Return form to: release@drpsonak.com or FAX to: **757-315-8052**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ E-Mail: _____

Authorization:

Method of information release: [ ] mail, [ ] email, [ ] fax, [ ] phone

I, _____, hereby authorize Ray Psonak D.O., & Health Always, to release my medical information to: (please print clearly)

Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

E-Mail: _____

NATURE OF REQUEST:

[ ] Letter to above named (explain nature of content requested below)
[ ] Phone Conversations
[ ] Lab records, [ ] Progress notes, [ ] Health Questionnaire
[ ] Complete Copy of My Medical Chart
[ ] Other (specify below)

PLEASE SPECIFY EXACTLY WHAT IS TO BE RELEASED, AND PURPOSE IF INDICATED

_____

_____

_____

_____

I understand I may revoke this authorization at any time by providing written notification. If there is a charge for these records, we will contact you.

_____ _____
Signature of Patient (if 18 years of age or older) DATE

_____ _____
Signature of Parent or Guardian (if minor patient) DATE