HealthAlways "Solutions for Life"

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Health Information Release Authorization

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

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ E-Mail: _____

Nature and Content of Request:

[ ] Phone Conversations
[ ] Letter to below named
[ ] Lab records, [ ] Progress notes, [ ] Medical History
[ ] Complete Copy of My Medical Chart
[ ] Other (specify below)

_____

_____

_____

Method of release:

[ ] phone conversation [ ] mail [ ] email [ ] fax

Patient Authorization:

I hereby authorize Ray Psonak D.O., and Health Always, to discuss my medical condition and/or release my medical information to: (please type or print clearly)

Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

E-Mail: _____

This Authorization will remain in force for one year from the date of signing. 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