Tyfanae Brinke, ANP
One life at a time, One day at a time!

Release of Medical Information

By signing this form, I, _____, authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the Physician/Person/Facility listed below.

Patient Name: _____ Date of Birth: _____

Contact Telephone Number: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Records
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Records
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (Please Specify Below)

_____

_____

_____

Release my protected health information:

From	To
Name: _____	Name: **Empower Medical and Wellness**
Fax: _____	Fax: **907-313-1417**

_____

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient / Parent or Guardian Signature Date