Chad M. Gonzales, M.D., P.C.

Authorization for Release of Protected Health Information

(For records from another Dr or office)

Date of request_____Medical Record #_____
Name of Patient_____
Date of Birth_____Phone #_____
Address_____City_____State____

INFORMATION TO BE RELEASED: (Check all that are applicable)
_____Most current visit with labs & x-ray
_____Patient information _____Lab reports _____X-ray reports
_____Office Visit notes _____ Pathology reports _____EKG reports
_____All records
Reason for request_____

I hereby authorize:

Name/
Entity_____

Address_____

City_____State_____ZIP_____
to release the above requested information contained in the medical record of the named patient for the date specified to:

Chad M. Gonzales, M.D., P.C.
4403 Harrison Blvd, STE 4410
Ogden, UT 84403
(801) 387-2550
Fax (801) 387-2574 or (801) 387-2564

I hereby release the above named provider from all legal liability that may arise from the release of information. This authorization is good for 90 days from the date signed.

Signature of Patient or Representative_____

Relationship to Patient_____
Date signed_____

Staff member who processed release_____
Date_____