Authorization to Release Protected Health Information
Dr. Angel Luis Perez MD, LLC
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Phone: (770) 255-4655 Fax: (770) 255-4672 Email: Office@drangelluisperez.com

_____ _____ _____/_____/_____

Patient Last Name: **First Name:** **Patient's Date of Birth**

_____ , _____ (____)_____-_____

Last and First Name of person signing (Parent, Guardian, or Patient, if 18 years or older) **Phone**

Check (√) one: [ ] I am the Patient (18 years of age or older) [ ] Parent [ ] Legal Guardian with custody

(Please state relationship with the patient.) _____

Records to be released:
[ ] To Dr. Angel Luis Perez **[ ] From Dr. Angel Luis Perez**

Whom you would like records to be [ ] sent to or [ ] received from:

3rd Party: _____
Mail:
_____ _____
Street Address or PO Box Number
_____, _____ _____
City State Zip

Telephone: (____) _____-_____. Fax to: (____) _____-_____

Applicable Dates of Service: From _____ **Through** _____

The purpose for which this release is being requested is:
[ ] Coordination of or Continued Care
[ ] Legal Action/Review
[ ] Insurance Reimbursement
[ ] Undeclared
[ ] Other: _____
Note: Any disclosure of information by the recipient(s) is prohibited.

This authorization expires _____ **(insert applicable date or insert 'no expiration') or in 6 months**
(12 months for school requests), whichever is shorter. No further use/disclosures may be made after expiration. Authorizations apply only for medical
records for specified treatment dates prior to and on the date of signature, unless otherwise specified.

Specified exceptions for future-dated releases: [ ] School [ ] Other: _____

Signature: _____ **Today's Date:** _____