Roots of Health
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Authorization to Release Medical Records

Patient name: _____
Date of birth: _____ Chart number: _____

I hereby authorize and request you to release to:
__Lonna Larsh, MD and Amber Weiss, PA-C
_____
_____
_____

A copy, summary, or narrative of my medical records as indicated by the checkmark(s) below, or otherwise release confidential information.

_____ Complete record
_____ Records of care from the following dates: _____
_____ Records concerning the following conditions: _____
__X___ Other, please specify: _____
_____ Confer with the following person(s) orally about my medical information: _____
_____

The reasons or purposes for this release of information are as follows: _____
_____
_____
_____
_____

Expiration date: _____ or expiration event as detailed below: _____
_____

- I understand that I may revoke this authorization in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosures by the recipient and no longer protected by federal or state law.

Patient signature: _____ Date: _____