

# Medical Records Release

Eric S. Hollabaugh, M.D, P.A

Edward Parry, M.D, P.A

(Authorization for Disclosure of Confidential Information)

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Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, hereby give permission to release any pertinent medical information, pathology results, and treatment performed by Eric S. Hollabaugh, M.D. or Edward Parry, M.D. to the following:

Dr. or Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dr. or Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

The authorization is given freely with the understanding that:

Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

A photocopy or fax of this authorization is as valid as this original.

I may revoke this authorization at any time, except where information has already been released. This Authorization is valid for sixty (60) days from the date it is signed, or sooner is noted below.

Eric S. Hollabaugh, M.D or Edward Parry, M.D., its employees, officers, and physicians, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature or Guardian

\_\_\_\_\_  
Revocation Date if Different from Above

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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## OFFICE USE ONLY

Information Disclosed To:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Information Disclosed By:

Fax

Authorization on File?

Orally

Authorization Date: \_\_\_\_\_

Mail

Authorization Expires: \_\_\_\_\_

Reason for Disclosure:

Specific Information Disclosed:

\_\_\_\_\_  
Printed Name of Individual Making Disclosure

\_\_\_\_\_  
Signature of Individual Making Disclosure

\_\_\_\_\_  
Date