KyreneInternalMedicine
Caring for Teens, Adults & Seniors

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Authorization To Release Medical Records TO Kyrene Internal Medicine

This information is from confidential records which are protected by State Law that prohibits further disclosure of the information without the specific written consent of the person to whom it pertains to, as otherwise permitted by law.

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	
Phone Number	Date of Birth		
Address	City	State	Zip

INFORMATION TO BE RELEASED

- ☐ All records Selected records only
- ☐ Mental Health
- ☐ HIV Testing
- ☐ Alcohol/Substance Abuse

PURPOSE / FOR INFORMATION

- ☐ Changing Physicians
- ☐ Further Treatment
- ☐ Insurance Reasons
- ☐ Other Reason:_____

COPIES TO BE RELEASED FROM		
Doctor's Name	Office Name	
Address		
City	State	Zip
Phone	Fax	
Signature of Patient or Legally Authorized Representative		Date