HAILEY, BRODY, CASEY & WRAY, M.D. P.C.

Consent for Release of Medical Information

Patient: _____ **DOB:** _____

Address: _____

Release from: Hailey, Brody, Casey, & Wray, M.D. P.C. _____

Address: _____

Phone #: _____ Fax #: _____

Release to: _____

Address: _____

Phone #: _____ Fax #: _____

Dates of records requested: From _____ to _____

Records will be used for: Acute Care ___ Continuation of Care ___ Second Opinion ___

Records shall be delivered by: Fax ___ Mail ___ Other _____

Patient Signature: _____ Date: _____

Patient's Legal Guardian Signature: _____ Date: _____

Printed Name of Legal Guardian: _____

This request is confidential and intended for the addressee only. Disclosure, copying, altering, or communication of this message if you are not the addressee is prohibited by law.