Marilee A. Hanson, M.D.

Mildred S. Hanson, M.D., PA
710 E. 24th. St. Suite 403
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Request for release of medical records from this office

Date_____

To: Dr. Marilee A. Hanson

From: Patient's full name and date of birth_____

Please release medical record information regarding my care to the following:

Doctor's name_____

Clinic Name_____

Address_____

Telephone number_____

Fax number_____

Specifically please include

____Lab reports
____Radiology reports
____Pathology reports
____Operative reports
____Narrative information
____Complete chart
____Other_____

I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one year from the date of my signature or a lesser period of time as specified here:_____. The expiration period noted here may exceed one year only in certain situations as specified by law.
I understand that once information is released pursuant to this authorization, Mildred S. Hanson M.D. PA cannot prevent the re-disclosure of the information to another third party.
I understand this authorization must be filled out completely and signed in order to be considered valid. A copy of this authorization is as valid as the original bearing my signature. Except for research-related treatment, Mildred S. Hanson M.D. PA will not condition treatment on my signing this authorization. I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities.
Name of patient (please print)_____

Signature of patient/Legal Representative_____

Legal Representative's authority to sign and date_____
Reason Patient is unable to sign_____Minor_____Deceased_____Other_____