OXYGENOASIS
A Center for Healing

PATIENTS AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please provide complete and accurate information when submitting this form. Only valid and complete forms will be processed.

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (Daytime): _____ Telephone (Evening): _____

I authorize release of my health care information concerning: *(please check off at least one of the following)*

☐ All health care records

☐ Treatment of *(please identify condition)*: _____

☐ Treatment received on the following dates: from _____ to _____

☐ Other *(please describe)*: _____

I authorize:

Facility: _____ Dr: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

To release my private health information as identified above to:

Facility: _____ Dr: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Please list the purpose or need of your health information: *(Please check one of the following)*

☐ Transfer of care ☐ Moving ☐ Seeing referred physician ☐ Other: _____

_____ _____

Patient Signature Date