CONSENT FOR RELEASE OF MEDICAL RECORDS
AND WAIVER OF CONFIDENTIALITY

Name:_____Phone #:_____

Address:_____DOB: _____

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I, hereby consent to the inspection, release, and photocopying of my entire medical record, chart, or file, and declare that I am authorized to give such consent, and further consent that copies be made available upon request to the **Emergency Medical Services Commission**, the Health Professional Licensing Office, their attorneys, investigators, and staff.

This consent authorizes any practitioner of the healing arts, including but not limited to medical and other health care providers, hospitals, clinics, suppliers of psychiatric, psychological, and counseling treatment, employers, or other persons to whom a signed original or photocopy of this consent is delivered to furnish any records in their possession, including patient histories, diagnoses, findings, treatment recommendations, prognoses, progress notes, entire hospital charts, physical therapy records, vocational rehabilitation records, worker's compensation records, psychiatric, psychological or counseling files including test data, substance abuse treatment records, and ambulance or paramedic records to the above-identified persons, their attorneys, investigators, and agents.

I further authorize the release or duplication of any and all x-ray films, myelograms, MRI films or other radiological studies for independent examination by the above-identified persons.

I specifically waive my physician-patient or other health care provider-patient privilege and right of confidentiality and privacy, and specifically authorize any such health care provider to discuss my physical and mental health condition(s) with the above-identified persons.

A photocopy of this authorization shall be considered as effective and valid as the original.

I declare under penalty of perjury that the foregoing is true and correct and executed of my own free will.

Executed on this_____day of_____, 202____.

_____

Signature of Patient or Authorized Representative, Including Legal Guardian, Health Care Agent, or Parent of Minor Child

Printed Name:_____

Relationship to patient: _____