

Fulton Family Health Associates, P.C.  
2613 Fairway Dr  
P.O. Box 6098  
Fulton, MO 65251

Tel: (573)642-1990  
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### Authorization to Release Medical Information

DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

I hereby authorize Fulton Family Health Associates, P.C. or specifically:

- \_\_\_\_\_ Robert P. Pierce, M.D.
- \_\_\_\_\_ Lisa J. Pierce, M.D.
- \_\_\_\_\_ Brice P. Windsor, D.O.
- \_\_\_\_\_ Andra Walker, PA

\_\_\_\_\_ To Release To:

\_\_\_\_\_ To Obtain From: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical records, including below, regarding the diagnosis and records of any treatment or examination rendered to me including, but not limited to HIV related information, mental health records, and substance abuse records.

- \_\_\_\_\_ All
- \_\_\_\_\_ Physicians Progress Notes
- \_\_\_\_\_ Hospital Records - All
  - \_\_\_ Operative Notes
  - \_\_\_ Consult Notes
  - \_\_\_ History & Physical
  - \_\_\_ Discharge Summary
- \_\_\_\_\_ Labs
- \_\_\_\_\_ Other \_\_\_\_\_

For the purpose of: \_\_\_\_\_

I release you from all legal responsibility or liability that may arise from the release of this information. I know that I have the right to revoke this release at any time. To revoke this release, I should contact the Office Manager for this office. I also know that this is subject to re-disclosure. I agree that these provisions will remain in effect until I provide written revocation. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Patient/Legal Guardian: **X** \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

*If we have requested medical records and there is a charge for them, please call our office for approval before making the copies.*