

Valley Internal Medicine, LLC

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Authorization For Release of Information

Patient Name: _____

Date of Birth: _____ SSN #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize (Name of Physician): _____ to disclose to **Valley Internal Medicine** medical records or any other information regarding my treatment, hospitalization, and/or outpatient care.

Information to be Released: _____

Dates of Treatment: _____

Purpose for disclosing information: _____

Date of Signature: _____

(Patient Signature)
(Patient's Legal Representative/Parent/Guardian)