



MEDICAL RELEASE OF INFORMATION

Authorization to Send Medical Records to Beacon IR Clinic

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Alternate: _____

PLEASE SEND RECORDS TO

Beacon IR Clinic

Fax: 833.468.5561

Phone: 833.473.6248

AUTHORIZATION

I, _____ (please print clearly), request and authorize the release of my health care information from the 12 months preceding the date of this authorization to Beacon IR Clinic, including diagnoses, medical records, physical examination findings, diagnostic imaging and reports, laboratory results, and treatment plans.

Provider / Facility releasing records: _____

IF YOU HAVE QUESTIONS ABOUT THIS REQUEST

Please call: ☐ Home ☐ Work ☐ Cell

Number: _____ Alternate number: _____

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Please leave a message asking me to return your call.
- ☐ The best time to reach me is (day) _____ between (time) _____.

SPECIAL INSTRUCTIONS / REQUEST

SIGNATURE

Patient/Legal Representative Signature

Date

Printed Name

Time ☐ AM ☐ PM