AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM. Completed forms may be emailed to infoform@savrx.com or mailed to 224 N. Park Ave Fremont, NE 68025.

I, _____(*Patient Name*), hereby authorize Sav-Rx Prescription Services to release my confidential health information by providing a copy of my medical records to the recipient listed below. I understand this information may include complete records, care plans, treatment records, medication/prescription records, and other summary of care.

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

_____

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO (*Recipient*):

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

_____ _____

Patient (or Legal Representative) Signature Signature Date

_____

Printed Name of Signer

_____

If Legal Representative, relationship to Patient

This authorization will expire twelve (12) months from the date of signature.