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Mary Ellen Coulter, MD
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AUTHORIZATION FOR RELEASE OF RECORDS

OBTAIN FROM:

PHYSICIAN/CLINIC: _____

ADDRESS: _____

PHONE: _____ FAX: _____

SEND TO:

PHYSICIAN/CLINIC:_____

ADDRESS: _____

PHONE: _____ FAX: _____

PLEASE CHECK SPECIFIC INFORMATION REQUESTED

ALL RECORDS:

HEALTH RECORDS FROM SPECIFIC DATES: _____

IMAGING AND LAB RESULTS

EXCEPTIONS:

DRUG AND ALCOHOL INFORMATION

HIV INFORMATION

MENTAL HEALTH INFORMATION

OTHER: _____

PATIENT'S NAME: _____ DOB: _____

PATIENT'S ADDRESS: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____

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