FLOYD COUNTY HEALTH DEPARTMENT

1917 Bono Road
New Albany, Indiana 47150-4607
Telephone (812) 948-4726
Fax (812) 948-2208
www.floydcountyhealth.org

MEDICAL RECORD RELEASE FORM

_____ _____
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to the Floyd County Health Department:

Name: _____ Telephone: _____

Address: _____ Fax: _____

_____

_____

Medical Information Requested:

[ ] All Records
[ ] Specific records from _____ to _____
[ ] Immunizations
[ ] Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}
[ ] T.B. Records

_____ _____
Signature of Patient or Legal Guardian Date

……..

TO BE COMPLETED BY A NOTARY PUBLIC

State of _____)

County of _____)

Subscribed and sworn to before me this _____day of _____, 20____.

_____proved to me on the basis of satisfactory evidence to be the person whose name is subscribed within this instrument and has acknowledged to me that he/she executed the same in his/her authorized capacity and that his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

My commission expires _____, 20_____

_____

Notary Public