Ascension
St. John Hospital
NEWLAND MEDICAL ASSOCIATES

Medical Records Authorization

Date: _________________________

I authorize the following **individuals** (i.e. spouse, parent, family member) to be able to receive my medical information, including, but not limited to test results, appointment confirmation and copies of medical records:

Name: _________________________
D.O.B:_________________________

Relationship: ____________________
Phone:_________________________

Name: _________________________
D.O.B:_________________________

Relationship: ____________________
Phone:_________________________

I understand that this authorization will be valid for one year or until I provide Ascension St. John Hospital Newland Medical Associates, with written confirmation that I no longer would like this individual to receive my medical information.

Signature:
