Medical Records Authorization

Date: _____

I authorize the following **individual** to be able to receive my medical information, including, but not limited to test results, appointment confirmation and copies of medical records:

Name:_____

Relationship to Patient:_____

Address:_____
_____
_____

Phone Number:_____

I understand that this authorization will be valid until I provide Newland Medical Associates, P.C. with written confirmation that I no longer would like this individual to receive my medical information.

Signature:_____
(Patient)