INFINITY
FAMILY CARE

104 Commerce St
PO Box 1039
Cadiz, KY 42211
270-512-2515 T
833-906-2579 F

Patient Name_____

DOB _____ SS #_____

Records released from

_____

_____

_____

I authorize you to release records to:

_____

_____

_____

Please enclose:

_____ Entire Medical Record
_____ Lab Reports
_____ Op Report
_____ Other _____

_____ Emergency Room Record
_____ Discharge Summary
_____ Radiology Reports

I authorize the release of my confidential medical records. I understand that these records may be used for current and future medical care, insurance claims processing, legal claims processing, and/or utilization review. This consent will remain in force for ONE YEAR after the signature date.

Patient/Guardian/POA _____

Date _____

Witness _____