



HIGH MOUNTAIN HEALTH, P.A.
Authorization for Release of Medical Records to Other Practices

DATE: _____

To: High Mountain Health

I authorize release of my medical records to:

Any information including the diagnosis and records of treatments and examination rendered to the above stated patient while under your medical care. Also release any pertinent medical records that you may have acquired from the patient's previous physician(s) and/or medical care/treatment/diagnostic centers if applicable.

Patient's Printed Name: _____

Patient's Signature: _____

Home Address: _____

Date of Birth: _____

Fee: \$35.00 per chart