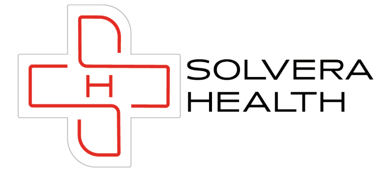
Medical Record Release Authorization



1

PATIENT CONSENT & AUTHORIZATION STATEMENT

Facility Name: ______________________________

This medical records release authorizes Solvera Health to obtain a complete set of my medical records from any physician, pharmacy, medical group, hospital, diagnostic laboratory, imaging center, or mental health treatment facility.

This consent and authorization shall be active for a period of one year from the date given below.

The signee understands that their express consent is required to release any health care information relating to testing, diagnosis, and / or treatment for HIV, sexually transmitted disease, psychiatric disorders, mental health, or drug and alcohol use.

2

PATIENT INFORMATION

______________________________ ______________________________

Patient Name | Date of Birth | Sex ◯ F ◯ M

PROVIDER INFORMATION

______________________________ ______________________________

Provider Name | Specialty

3

______________________________ ______________________________

PATIENT SIGNATURE | DATE

______________________________ ______________________________

PARENT / LEGAL GUARDIAN SIGNATURE | RELATIONSHIP TO PATIENT

SOLVERA HEALTH STAFF | REVIEWED BY ______________________ DATE APPROVED ______________