

Authorization for release of  
Medical Information



When ready please  
call \_\_\_\_\_  
mail \_\_\_\_\_

RECORDS **TO** HORIZONS MEDICAL CARE, P.C.

Completed yes no  
Date \_\_\_\_\_  
Initials \_\_\_\_\_

I hereby authorize:

to release medical records to:

\_\_\_\_\_  
Your Physician or name of person releasing information

Horizons Medical Care. P.C.

Attn: Medical Records

P.O. Box 888

8045 Highway 72 West, Suite 100

Madison, AL 35758

Phone: 256-837-2271

Fax: 256-837-2910

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone #

Please release the medical records in your possession concerning my/my child's illness and/or medical treatment as specified below:

All records (including, but not limited to, medical history, physical condition, x-rays, lab studies and/ or treatment

Specific information \_\_\_\_\_

Include AIDS information

Include HIV Information

Include Psychiatric, Psychological Information

Include Drug Abuse and/or Alcoholism Info

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\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone #

All records (including, but not limited to, medical history, physical condition, x-rays, lab studies and/ or treatment

Specific information \_\_\_\_\_

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Include HIV Information

Include Psychiatric, Psychological Information

Include Drug Abuse and/or Alcoholism Info

\_\_\_\_\_  
Patient's Name (s) (**Please print**)

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Date(s) of Birth

\_\_\_\_\_  
Patient/Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Parent/Legal Guardian Address/City/State/Zip

\_\_\_\_\_  
Phone Number