LIMITED MEDICAL AUTHORIZATION

TO: _____

_____

_____

Patient Name: _____
Date of Birth: _____ Social Security Number: _____

The dates of treatment requested are: _____

I hereby authorize you to furnish all of the medical records, charts, reports, treatments, diagnoses, and medical bills in your possession concerning your care and treatment of the aforementioned Patient to the following designated holder of this Limited Medical Authorization:

Designated Holder: _____
On Behalf of: _____
Address: _____

All expenses for obtaining said documents are to be borne by the aforementioned Holder of this Limited Medical Authorization.

This Limited Medical Authorization is extended to said Holder with the explicit understanding that the Holder is to provide a copy of each and every request for medical information which he/she makes to a health care provider of Patient, as well as a copy of each and every record, chart, report, etc. received by said Holder from the use of this Authorization to Patient:

Patient Name
Patient Address
Patient City, State Zip Code

These copies will be provided "without charge" by said Holder to Patient.

It is also understood by said Holder that this Limited Medical Authorization **DOES NOT ALLOW** said Holder to have **ORAL CONFERENCES** with any of Patient's health care providers outside the presence of Patient. This Limited Medical Authorization is provided only for the purposes of obtaining written records and/or documentation **already in existence** and generated by Patient's health care providers as of the time of the use of said Limited Medical Authorization. The Holder of this Limited Medical Authorization **SHALL NOT REQUEST** a health care provider to draft narratives, reports, etc. which have not already been requested by Patient, and/or which are not already in existence.

The below named patient has been advised of the following and understands that:

I. His/Her right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

II. The information released in response to this authorization may be re-disclosed to other parties.

III. His/Her treatment or payment for treatment cannot be conditioned on the signing of this authorization.

*This authorization will expire **60 days** from the date signed below.*

PATIENT / AUTHORIZED REPRESENTATIVE

Date: _____