



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/HEALTH INFORMATION

I hereby authorize any physician, surgeon, hospital, insurance company, vocational rehabilitation office or any mental or public health care facility to release to MyDoctor LLC. All medical records or other evidence in their possession regarding my treatment, medical history, hospitalization and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, or genetic testing, or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infection with Human Immunodeficiency Virus (HIV). A photographic copy of this authorization shall be valid as the original.

Release records from:

Name: _____

Address: _____

Phone: _____

Release records to:

Name: MyDoctor LLC.

Address: 10229 N. 92Street, Suite I-103, Scottsdale, AZ 85258

Phone: (877) 818-6300 Fax: (866) 819-6115

Specific description of information to be disclosed:

_____ Complete Medical Record _____ Lab _____ X-Ray
_____ Admission/Discharge Summary _____ Operative Reports
_____ Other _____

NAME (please print) _____

DATE OF BIRTH: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____