FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

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Authorization for Fagadau, Hawk, & Swanson M.D. to RECEIVE the medical record information of:

Patient Name: ___________________________ **D.O.B.** __________ **Phone:** __________________________

Patient's Address: ____

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I authorize Fagadau, Hawk, & Swanson M.D., LLP to RECEIVE my health records from:

Doctor/Company:____

Address: ____

Phone: ____

Fax: ____

- ☐ **Complete record**
- ☐ **Records of care from the following dates** _____________________ **to** ___________________
- ☐ **Records concerning the following conditions** ____
- ☐ **Other, please specify** ____

The reasons or purposes for this release of information are as follows:

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____

Patient/ Legal Guardian Signature: ____ **Date:**___________