



**Medical Records  
Electronic Transmission Authorization**

I, \_\_\_\_\_, authorize this clinic to transmit my medical records electronically. If another party receives them in error, I absolve this clinic and Dr. \_\_\_\_\_ of any and all liabilities relating to such submission of said records.

*This authorization does NOT apply to records pertaining to drug, alcohol, or psychiatric treatment.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Witness

**Not valid if presented more than ninety (90) days from date of authorization.**

**Not valid if dated prior to treatment period.**