General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Darcy J. Hansen, MD
1145 19th Street, N.W., Suite 210
Washington, DC 20036

Patient Name: ____
Address: ____
____
Phone: ____
SSN : ______________________ Date of Birth: ____________

I authorize:
____
____

To release my medical records to:

Darcy J. Hansen, MD
1145 19th St N.W., Suite 210
Washington, DC 20036
(202) 223-6199 phone
(202) 223-6799 fax

These records are for services provided on the following date(s):___________

Patient's Signature: ____
Date of Request: ____
Expiration of Request: ____