

**Medical Records Release Form  
Authorization to use & Disclose Health Information**

I authorize Robert Lang, M.D., P.C. to disclose a copy of the specific health and medical information described below regarding:

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Name of Patient

Consisting of: **Bone Density (DEXA)**

(Describe information sought, misdates, to be used/disclosed here)

Name of Recipient: \_\_\_\_\_

Address Recipient: \_\_\_\_\_

For the purposes of : **Evaluation and report to ordering physician and other providers at patients request.**

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Signature of Patient

Printed Name of Patient

Date

You have the right to revoke this Authorization at any time, provided you do so in writing and except to the extent that we have already used or disclose the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicate, this Authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.