## MEDCIAL RECORDS RELEASE FORM

Address:  City: State: Zip Code:  Date of Birth:  I authorize the release of my confidential health information to the physician/person/facility/entity and/or those associated in my medical care listed below:  For the period of: to	Patient Name:			
Date of Birth:	Address:			
I authorize the release of my confidential health information to the physician/person/facility/entity and/or those associated in my medical care listed below:  For the period of: to				
associated in my medical care listed below:  For the period of:	Date of Birth:			
Records requested from: Facility/Person Name: Address: City: State: Zip Code: Phone: Fax:  Records disclosed to: Facility/Person Name: Address: City: State: Zip Code: Phone: Fax:  The information which may be released are as follows: Prescriptions Only Complete Records Prescriptions Only Complete Records Prescriptions Only Complete Records Prescriptions Only Other			nformation to the physician/person/facility/entity and/or those	direc
Facility/Person Name:  Address:  City: State: Zip Code:  Phone: Fax:  Records disclosed to:  Facility/Person Name:  Address: State: Zip Code:  Phone: Fax:  The information which may be released are as follows:  Complete Records  Lab Reports Only  Radiology Reports Only	For the period of:	to	to	
Address:  City: State: Zip Code:  Phone: Fax:  Records disclosed to:  Facility/Person Name:  Address:  City: State: Zip Code:  Phone: Fax:  The information which may be released are as follows: Prescriptions Only  Complete Records Lab Reports Only Radiology Reports Only	Records requested from:			
City: State: Zip Code: Phone: Fax:  Records disclosed to: Facility/Person Name: Address: State: Zip Code:  City: State: Zip Code:  Phone: Fax:  The information which may be released are as follows: Prescriptions Only Other  Lab Reports Only Other	Facility/Person Name:			
City: State: Zip Code: Phone: Fax:  Records disclosed to: Facility/Person Name: Address: City: State: Zip Code: Phone: Fax:  The information which may be released are as follows: Prescriptions Only Other Other	Address:			
Phone: Fax:				
Records disclosed to: Facility/Person Name: Address: City: State: Zip Code: Phone: Fax:  The information which may be released are as follows: Complete Records Lab Reports Only Radiology Reports Only				
Facility/Person Name:  Address:  City:  State:  The information which may be released are as follows:  Complete Records  Lab Reports Only  Radiology Reports Only				
Address: State: Zip Code: Phone: Fax:   The information which may be released are as follows: Prescriptions Only    Complete Records Prescriptions Only Other   Radiology Reports Only	Records disclosed to:	W		
City: State: Zip Code: Phone: Fax:  The information which may be released are as follows: Prescriptions Only Complete Records Prescriptions Only Other	Facility/Person Name:			
Phone: Fax:  The information which may be released are as follows:  Complete Records Lab Reports Only Radiology Reports Only	Address:			
The information which may be released are as follows:  Complete Records Lab Reports Only Radiology Reports Only	City:	State:	Zip Code:	
<ul> <li>□ Complete Records</li> <li>□ Lab Reports Only</li> <li>□ Radiology Reports Only</li> </ul>	Phone:	Fax:		
	<ul><li>☐ Complete Records</li><li>☐ Lab Reports Only</li></ul>		☐ Prescriptions Only	
Please select the reason for request:	Please select the reason for a	request:		
☐ Continued Patient Care ☐ Personal ☐ Other				
<ul> <li>□ Worker's Compensation</li> <li>□ Attorney/Legal</li> <li>□ Social Service/Disability</li> </ul>	*	on		
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	Patient Name		Date	
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	Patient Signature			

