MEDCIAL RECORDS RELEASE FORM

Patient Name: _____

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 directly associated in my medical care listed below:

For the period of: _____ to _____

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:

- ☐ Complete Records
- ☐ Lab Reports Only
- ☐ Radiology Reports Only
- ☐ Prescriptions Only
- ☐ Other _____

Please select the reason for request:

- ☐ Continued Patient Care
- ☐ Worker's Compensation
- ☐ Attorney/Legal
- ☐ Personal
- ☐ Insurance
- ☐ Social Service/Disability
- ☐ Other _____

_____ _____

Patient Name Date

_____

Patient Signature