**Medical Records Release Form**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Full Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Date of Birth

**The information you may release subject to this signed release form is as follows:**

|  |  |  |
| --- | --- | --- |
| * Complete Medical Records * Care Plan * Pathology Reports | * Lab Reports * Treatment Record * Medication Record | * Radiology Reports * History & Physical * Other (Please explain below) |

Other:

**Release my health information to the following physician/person/facility/entity and/or those directly associated with my medical care:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State ZIP

**The purpose/reason for this release of information is as follows:**

**Authorized By:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Legal Representative Signature of Patient or Legal Representative

\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed