Authorization for Release of Medical Records

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _____. hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

Patient Name: _____ Record Number: _____

Address: _____ Date of birth: _____

Records Requested: _____

Purpose of Release (please circle): Moving 2nd opinion Changing Providers Personal

Other: _____

Records to be provided to:

Name of Person/Facility/Office: _____

Phone Number: _____

Records to be sent via (please circle): Secured Email Fax Mailing Address

Please provide email, fax or mailing address:

_____

_____

Patients Signature or Patients Representative ***Date***

_____

Printed Name of Patients Representative ***Relationship to Patient***

This information is to be release for the purpose stated above and may not be used by the recipient for any other purpose.

Please make a copy of this release for your records.

✳Under HIPAA with a patient written request, our office provides records within 30 days of a request✳
HIPAA Authorization for Release of Medical Records
This form does not constitute legal advice and covers federal, not state law.

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