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MEDICAL RECORDS RELEASE

Authorization To Release Medical Records/Information

Patient Name: _____ **Date of Birth:** _____

Phone #: _____ **SSN:** _____

Physician/facility to provide medical records: _____

Address: _____
Street City/ State / Zip

Phone #: _____ Fax #: _____

Please Release My Records To: _____

Address: _____
Street City/ State / Zip

Phone #: _____ Fax #: _____

I request a copy or summary of the following medical records: (please ☑ all that apply)

☐ Complete Medical Record ☐ Specific Office Visit(s)

☐ Pathology/Biopsy Report(s) ☐ Lab Report(s)

☐ Other: _____

Please ☑ one:

☐ For dates of service from ____/____/____ to ____/____/____

☐ For all dates of service

I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire 12 months from the date signed.

Patient Name (Print):

_____

Person Authorized to sign for patient:

_____

Patient Signature:

_____

Signature/Relationship to patient:

_____

Date: _____

Date: _____

(office use only) Date request sent: _____