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MEDICAL RECORDS RELEASE

Patient Name _____ SSN # _____

Address _____ Date of Birth _____

City/State/Zip _____ Phone # _____

I Hereby Authorize: (records to be obtained from)

Release To:

Print name of Doctor or Facility

Print Name of Doctor or Facility

Address

Address

City/State/Zip

City/State/Zip

Phone

Fax

Phone

Fax

Date of next appointment (for which records will be required)

The specific information to be disclosed is:

- | | |
|--|---|
| ☐ Physician's chart notes | ☐ Operative reports |
| ☐ X-ray reports | ☐ Laboratory reports |
| ☐ Ultrasound report | ☐ Financial records |
| ☐ Pathology reports | ☐ Immunizations |

- ☐ Other _____
- ☐ Information which may not be disclosed _____

Special dates of interest: _____ to _____.

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it.

I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment. By signing below, I hereby authorize the disclosure of information about me that is protected under federal law, for the sole purpose and time period designated. I understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

I understand this authorization will expire one year from the date signed unless otherwise specified:

Expiration Date

Patient Signature or Personal Representative

Date

As a personal representative, I have authority to act for the individual because I am:
