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Medical Records Release

Patient Name ____
Address ______________________________ Birth date ______________
______________________________ SS # ______________
______________________________ Phone ______________

I Authorize ______________________________ to release my medical records
Address ______________________________ Phone ______________
______________________________ Fax ______________

I authorize the release of the following: (Please check all that apply)

- ☐ All Records
- ☐ Surgery/Procedure Notes
- ☐ History and Physical
- ☐ Lab Results
- ☐ All records between dates ____/___/___ to ___/____/____
- ☐ Test results
- ☐ Visit notes
- ☐ Other: ______________________________

Please read carefully.

☐ **I do not authorize the release of the following information:**
Confidential information related to HIV, communicable disease, alcohol or drug use, and mental health diagnosis and treatment.

Please release my records to:______________________________
Address ______________________________ Phone ______________
______________________________ Fax ______________

Reason for Request: ______________________________

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.
- This authorization will expire in **60** days.

Signature of patient or authorized guardian		Date	
Witness Signature		Date	

*****Please be aware that there will be a $25.00 fee due upon request for copies of medical records.*****

*****Please allow 7-14 days for processing.*****