Medical Records Request and Transfer Form

Instructions: Please complete all sections below to authorize the transfer of medical records. Print the completed form, sign, and date it.

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1. Patient Information

Full Name:		Date of Birth:	MM/DD/YYYY
Phone Number:		Email Address:	
Street Address:			

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2. Release Records FROM (Current Facility/Provider)

Facility Name:		Provider Name:	
Phone Number:		Fax Number:	
Street Address:			

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3. Send Records TO (New Facility/Provider)

Facility Name:		Provider Name:	
Phone Number:		Fax Number:	
Street Address:			

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4. Information to be Transferred

Please specify the records you wish to transfer (e.g., All Records, Lab Results, Imaging Reports, Specific Dates of Service):

Records Requested:	e.g., All Medical Records from 2020 to Present
Purpose of Disclosure:	e.g., Transfer of Care, Personal Use, Legal

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5. Authorization and Signature

I hereby authorize the release and transfer of my medical records as specified above. This authorization is valid until revoked in writing.

Patient/Authorized Representative Signature:	Sign here after printing	Date:	MM/DD/YYYY
Relationship to Patient (if applicable):	Self, Parent, Legal Guardian, etc.		