Specialist Referral Medical Records Release Form

Please complete all sections of this form to authorize the release of your medical records to the designated specialist.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Home Address:

2. Releasing Provider (Current Clinic/Doctor)

Clinic or Doctor Name:

Phone Number:

Fax Number:

3. Receiving Specialist (Referral Clinic/Doctor)

Specialist Name or Clinic Name:

Medical Specialty:

Phone Number:

Fax Number:

4. Information to be Released

Please specify the medical records to be transferred (e.g., "All records", "Last 2 years of progress notes", "Lab results and imaging only"):

Purpose of Disclosure:
Specialist Referral and Continuity of Care

5. Authorization and Signature

By signing below, I authorize the release of my health information as described above. I understand that this authorization is voluntary and that I may revoke it at any time in writing.

Patient or Authorized Representative Signature:

Relationship to Patient (if signed by Representative):

Date Signed (MM/DD/YYYY):