

Medical Records Release and Request Form

This form authorizes the release of medical records in accordance with HIPAA regulations. Please complete all sections to expedite your request.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Street Address:

City, State, Zip:

2. Records Released FROM

Specify the healthcare provider, clinic, or hospital currently holding the records.

Facility/Provider Name:

Address:

Phone Number:

Fax Number:

3. Records Released TO

Specify where the requested medical records should be sent.

Recipient Name/Organization:

Address:

Phone Number:

Fax Number:

Delivery Method (e.g., Mail, Fax, Email, Pickup):

4. Information to be Disclosed

Detail the specific records to be released (e.g., "All records", "Lab results only", "Records from Jan 1, 2023 to Dec 31, 2023").

Description of Records:

Specific Dates of Service:

Purpose of Disclosure (e.g., Personal Use, Continuity of Care, Legal):

5. Sensitive Information Authorization

By signing below, you authorize the release of sensitive medical information if it is contained within your records. If you wish to exclude any of the following, please type "EXCLUDE" in the corresponding box.

Drug, Alcohol, or Substance Abuse Treatment Records:

Mental Health / Psychotherapy Records:

HIV / AIDS Testing or Treatment Information:

6. Patient Authorization and Signature

I understand that I have the right to revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Patient Signature: _____ Date:

If Representative, Legal Guardian, or Authorized Agent:

Representative Name:

Relationship to Patient:

Representative Signature: _____ Date: