Medical Records Release Authorization

Please complete all sections of this authorization form to facilitate the release of medical records.

1. Patient Information

Patient Full Name:

Date of Birth: MM/DD/YYYY

Phone Number:

Email Address:

Street Address:

City, State, Zip:

2. Authorization to Release Information From

Identify the doctor, hospital, or clinic holding the records:

Facility/Provider Name:

Address:

Phone:

Fax:

3. Recipient Information

Identify where the records should be sent:

Recipient Name/Facility:

Address:

Phone:

Fax:

4. Information to be Released

Describe the specific records to be disclosed:

Specific Dates of Service: e.g., Jan 2023 - Dec 2023

Types of Records (e.g., Progress Notes, Lab Results, Imaging):

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

5. Expiration and Revocation

This authorization will expire on (Date or Event): MM/DD/YYYY or Event

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

6. Patient Authorization and Signature

By signing below, I authorize the release of my medical records as described above.

Signature of Patient or Legal Representative: Sign on printed copy

Date: MM/DD/YYYY

Relationship to Patient (if Representative):