INSURANCE COMPANY MEDICAL RECORDS REQUEST FORM

Instructions: Please complete all sections of this form to authorize the release of medical records to your insurance company. Print the completed form, sign, and submit it to your provider or insurance representative.

---

1. Patient Information

Patient Full Name:		Date of Birth (MM/DD/YYYY):	
Phone Number:		Email Address:	
Street Address:		City:	
State:		Zip Code:	

---

2. Insurance Policy Information

Insurance Company Name:		Policy / Member ID Number:	
Group Number:		Policy Holder Name:	
Relationship to Patient:			

---

3. Medical Records Requested From (Healthcare Provider)

Provider or Clinic Name:		Provider Phone Number:	
Provider Address:		Provider Fax Number:	

---

4. Description of Medical Records to Release

Service Dates From:		Service Dates To:	
Specific Information (e.g., Progress Notes, Lab Reports, Imaging):		Purpose of Disclosure:	Insurance Underwriting an

---

5. Patient Authorization and Signature

I hereby authorize the healthcare provider listed in Section 3 to release my medical records to the insurance company listed in Section 2. I understand that this authorization is voluntary and that I may revoke it at any time in writing.

Printed Name of Patient / Representative:	
If Representative, State Authority (e.g., Parent, Guardian):	
Date (MM/DD/YYYY):	
Physical Signature (Sign after printing):	