MEDICAL RECORDS RELEASE

Patient Name: ______________________________________________ DOB: ____________________________

**I authorize the following custodian/entity to release the requested Medical Records.**

Physician/Hospital: ____________________________________________

Address: ____________________________________________

Phone: ____________________________________________

Fax: ____________________________________________

Records should be released for the following dates: ______________________ to ______________________

**Mark which of the following information is to be released.**

| | | | |
|---|---|---|---|
| All Records | | Medical Records | |
| Lab/Pathology Reports | | Progress Notes | |
| Radiology | | Treatment Records | |
| Billing Records | | Pharmacy/Prescription Records | |
| Care Plan | | Operative Reports | |
| Hospital Records | | Other (please list) | |

If these records contain information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or STDs, you are hereby authorizing the disclosure of this information.

**Please send the request records by mail or fax to the following location.**

Physician/Hospital: ____________________________________________

Address: ____________________________________________

Phone: ____________________________________________

Fax: ____________________________________________

**By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of the PHI listed above.**

______________________________________________________________________________

**(**Patient's Signature or Guardian's If Minor) (Date)