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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: ______________________ **Date of birth**: ______________________

The information you may release subject to this signed release form is as follows:

☐ Cornplete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Records	☐ Operative Reports
☐ Hospital Reports	☐ Medication Records	☐ Other (Please Specify)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: ______________________

Address: ______________________

city: ____________ St: ____________ zip code: ____________

The purpose/reason for this release of information is as follows:

Signature/ Date ______________________

Signature of Patient or Personal Representative: ______________________

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