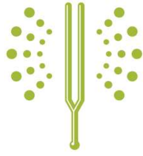

CONSENT TO RELEASE MEDICAL RECORDS

Please fill out only if we need to request records from other Doctors.

Patient name: ________________________________ Home Number: ___________________

Date of birth: ________________________________ Cell Number: ____________________

I hereby authorize and request that ____
Name of facility/individual

____
Address **City/State/Zip** **Phone number and Fax**

Release information from my records to the following:

Name of the Facility/individual: ____

____
Address City/State/Zip

____
Fax number, if applicable

Please be specific regarding record and dates requested Information to be released:

Diagnosis and record of treatment ____
Specific date/dates requested

Laboratory and/or X-ray reports ____
Specific date/dates requested

Entire file (excluding confidential and psychiatric records, if any)

Other____

Be advised that if you are requesting a copy of your medical record, a copying fee shall apply.

It is prohibited by law to release/disclose the attached/enclosed information to anyone except those specified above. I understand that this Authorization alone may not authorize release psychiatric or HIV information.

In signing, I am aware that this Authorization is valid for 30 calendar days after today

____
Patient Signature Date

DISPOSITION/DATE: Mailed certified/return receipt requested (date) _________________
Faxed (date and time) __________________________ ID verification by_______________

Records given to patient / date and time____________ Provider's approval_______________

Patient will pick up ☐ Patient Paid: Date:______________________