Medical Records Release Form

Patient authorization to share medical records

Patient Information

Patient Full Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____

Release From (Provider Holding Records)

Provider / Facility Name: _____

Provider Address / Phone / Fax: _____

Release To (Recipient)

Recipient Name / Organization: _____

Recipient Address / Phone / Fax: _____

Records to Release

- ☐ Complete medical record for dates: _____ to _____
- ☐ Test / lab results only
- ☐ Imaging and reports
- ☐ Immunization records
- ☐ Billing records
- ☐ Other: _____

Purpose of Release (e.g., continuing care, personal use, insurance, legal): _____

Authorization

I authorize the provider named above to release the records described to the recipient named above. I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. Unless revoked earlier, this authorization expires on: _____ (or one year from the date signed if left blank).

Patient (or Legal Representative)

_____

Signature

_____

Printed Name

Date