



## Medical Records Release Form

### PATIENT INFORMATION

- **Patient Name:** \_\_\_\_\_
- **Date of Birth:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### AUTHORIZATION TO RELEASE RECORDS

I hereby authorize the release of my personal health information during the term of this authorization to the recipient(s) identified below:

- **Release From (Name/Facility):** \_\_\_\_\_
- **Release To (Recipient Name):** \_\_\_\_\_
- **Recipient Address:** \_\_\_\_\_
- **City / State / Zip:** \_\_\_\_\_
- **Fax Number:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### RECORDS TO BE RELEASED *Please check the desired option:*

- **All Health Information:** Includes all medical history, mental/physical conditions, and treatments in the provider's possession.
- **Limited Records Only:** *(Please specify)* \_\_\_\_\_

**Purpose of Release:** \_\_\_\_\_

*(Note: "At the request of the patient" is sufficient if initiated by the patient)*

### TERMS & SIGNATURE

- This authorization will remain in effect from the date signed until: \_\_\_\_ day of \_\_\_\_\_, 20\_\_
- *I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party not bound by federal/state privacy laws.*
- **Patient/Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_
- *If signed by a parent, legal guardian, or responsible party, please print name and state relationship:*  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
- **Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_