Medical Record 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/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:

__ Complete Records	__ History and Physical	__ Progress Note
__ Care Plan	__ Lab Reports	__ Radiology Reports
__ Pathology reports	__ Treatment Record	__ Operative Reports
__ Hospital reports	__ Medication Record	__ 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, State, Zip Code: _____
Phone Number: _____ Fax Number: _____

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

Patient Signature: _____Date: _____

_____ _____
Patients Name Signature of Personal Representative

_____ _____
Patients Date of Birth Printed Name of Personal Representative

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