Authorization for Release of Medical Records

Requesting Records From: ____

____

Patient Name: ____

DOB: ____

Patient Address: ____

____

Patient Phone Number: ____

Other Names Used: ____
(Maiden name, nickname, etc.)

Please release the following medical records of the patient named above to: ____________________

____

____

Fax records to (location / fax number):

____

____

___ History & Physical Exam

___ Operative Notes

___ Progress Notes

___ Consultation Reports

___ Pathology, Lab & X-ray

___ Other: ____________

I hereby authorize the release of any information from my exam including diagnostic tests and photographs. This does not authorize re-release of the information to anyone. A photocopy will be treated as the original.

Patient's signature: ______________________________ Date: ____________________