Authorization for Release of Medical Records

Print patient's full name	Birth date (Mo/Day/Yr)	Phone

Street Address	City, State, Zip Code

Requested Records:

□ All medical information □ Lab results □ Progress notes □ X-ray / CT / Ultrasound
□ OB care □ Operative & Pathology reports □ Other _____

Send Records To:

MD / Practice Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Copy Records From:

MD / Practice Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I UNDERSTAND AND ACKNOWLEDGE THAT THE RECORDS MAY INCLUDE ALCOHOL/DRUG, MENTAL HEALTH OR HIV/AIDS INFORMATION.

Purpose of Disclosure:

□ Referral to Specialist □ Insurance □ Transfer of care □ Legal Investigation

□ Disability Determination □ Second Opinion □ Coordination of care □ Other _____

I understand that I may revoke this authorization at any time, in writing, and that the revocation will not apply to information that has already been released. Unless otherwise noted, this authorization will expire six months from the date on which it was signed.

Processing this request will require a minimum of 7-10 business days.

Date: _____ Signature: _____

Date: _____ Witness: _____

Date Completed: _____ Signature: _____

Faxed: _____ Mailed: _____ Picked up: _____

This release contains confidential information. If you are not the intended recipient of this release or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any distribution or copying of this fax is strictly prohibited. If you have received this release in error, please notify us by telephone.

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