Medical Records 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 or narrative of my protected health information, to the doctor/clinic/person/entity listed below.

Patient Name: D.o.B:

The information you may release, authorized by this signed release form, is as follows:

01. ______________________________ 02. ______________________________
03. ______________________________ 04. ______________________________
05. ______________________________ 06. ______________________________
07. ______________________________ 08. ______________________________
09. ______________________________ 10. ______________________________
11. ______________________________ 12. ______________________________

My medical records and other confidential health information may be released by you to the following:

Name: ____
Address: ____
Relation to Patient: ____
Reason: ____

[Patient’s Signature]

____

([Name of the Patient])