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Authorization for Release of Medical Records

Requesting Records From: _____

_____

_____

Patient Name: _____

Date of Birth: _____

Patient's Address: _____

_____

Patient's Phone Number: _____

Other Names Used: _____

(Maiden name, nicknames, etc.)

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

_____

_____

Fax records to this number: _____

_____	History & Physical Exam	_____	Consultation Reports
_____	Operative Notes	_____	Pathology, Lab & X-ray
_____	Progress Notes	_____	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: _____