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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:_____