Medical Records Release

(Name of Patient) _____ (Date of Birth) _____

(Street Address) _____ (City, State, Zip Code) _____

Authorizes:

(Name of Physician) _____

(Name of Healthcare Facility) _____

(Street Address) _____

(City, State, Zip Code) _____

Release of Records to:

(Name of Physician) _____

(Name of Healthcare Facility) _____

(Street Address) _____

(City, State, Zip Code) _____

Information to be released:

- ☐ All Clinic Records
- ☐ Eye Records
- ☐ Office Notes
- ☐ Photographs
- ☐ Visual Fields
- ☐ X-Ray Reports
- ☐ Immunization Records
- ☐ X-Ray Films (Specify) _____
- ☐ Allergy Reports
- ☐ Lab Reports
- ☐ Electrocardiograms
- ☐ Other (Specify) _____

List other facilities records to be included when releasing for the purpose of continuing Medical care: _____

For the Following Dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- ☐ Mental Health
- ☐ Alcoholism
- ☐ Other (Specify) _____
- ☐ AIDS test results
- ☐ AIDS related disease
- ☐ Drug Abuse
- ☐ Developmental disability

Purpose of need for disclosure: (check all applicable categories)

- ☐ Further medical care
- ☐ Insurance Application
- ☐ Other (Specify) _____
- ☐ Payment of insurance
- ☐ Personal
- ☐ Legal investigation
- ☐ Vocation rehabilitation evaluation

I understand that this authorization shall be valid for one year unless otherwise stated below or revoked through written notice to Medical Records. _____ (Alternate date if not one year)

I authorize release of my medical records in accordance with that specifications listed above. I understand written notice is necessary to cancel this request.

(Signature of Patient or Responsible Party) _____ (Date) _____

(Printed Name of Responsible Party) _____ (Relationship to Patient) _____

Patient is: ☐ Minor ☐ Disabled ☐ Deceased ☐ Incompetent

Legal Authority: ☐ Legal ☐ Legal guardian ☐ Next of kin deceased