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# 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 physician/person/facility/entity listed below.

**Patient Name:** _____ **Date of Birth:**_____

**Requesting records from:** _____

**The information you may release subject to this signed release form is as follows:**

| | | |
|---|---|---|
| ☐ Complete Records | ☐ History & Physical | ☐ Progress Notes |
| ☐ Care Plan | ☐ Lab Reports | ☐ Radiology Reports |
| ☐ Pathology Reports | ☐ Treatment Record | ☐ Operative Reports |
| ☐ Hospital Reports | ☐ Medication Record | ☐ Other (please specify below) |

**The purpose/reason for this release of information is as follows**:

_____

_____

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**Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:**

Name:_____

Address:_____

City: State: Zip Code:_____

## Signature:

_____ _____

Patient Name Printed — Signature of Patient or Personal Representative

_____ _____

Date — Description of Personal Representative's Authority