



Medical Records Release Form

Patient Information

Patient Full Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Authorizing Party (if different from patient)

Name/Entity: _____

Relationship to Patient: _____

Phone: _____

Email: _____

Information to be disclosed:

Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consultations, billing records, insurance records, and records from other health providers

Medical Records from (insert date) ____/____/____ to ____/____/____

Other _____

Include (Indicate by Initialing)

_____ HIV/AIDS – Related Information (Including HIV/AIDS Test Results)

_____ Mental Health Records (Except Psychotherapy Notes)

_____ Drug, Alcohol or Substance Abuse Records

_____ Genetic Information (Including Genetic Test Results)

Destination of release:

To: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Purpose of release:

Continuing medical care

Legal matters

Insurance/claims

Disability determination

Other: _____

Confidentiality acknowledgment (if applicable):

Mental health records

Substance use treatment records

HIV-related information

Personal Use

Billing or Claims

Legal Purposes

Other: _____

Authorization and revocation right:

I understand that I may revoke this authorization at any time by sending written notice to the medical provider, except to the extent that action has already been taken in reliance on this authorization.

I understand that records released may be re-disclosed by the recipient and may no longer be protected by federal privacy laws.

I understand that this authorization will expire after 30 days or upon completion of the purpose stated above, whichever comes first.

Patient or legal representative authorization signature: _____

Patient

Legal representative, describe authority: _____

Printed name: _____

Date: _____