Reyes and Reyes, MD, PA
Better Health Starts Here

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Medical Records Release/Request Form

(Check One)
Release _____ Releasing information from us to you or your provider
Request _____ Requesting information from another provider to us

Date:_____

Name:_____ Date of Birth:_____

Street Address:_____

City, State and Zip:_____

Home Telephone Number:_____

I authorize Reyes and Reyes, MD, PA to release/request *(circle one)* the following:
Information Requested:_____

_____

Purpose of Request:_____

Duration of Authorization:_____

To/From *(circle one)*:_____

Street Address:_____

City, State and Zip:_____

Phone and Fax:_____

(It is important that you give as much contact information as you can, especially the provider's name and phone)

- I understand that this authorization shall be valid through _____(date), but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.

Signature:_____ Date:_____

Witness:_____ Date:_____