MEDICAL RECORD RELEASE FORM

Please complete this form and fax to the physician, hospital, or organization from which you are requesting records. This information will then be forwarded directly to our office.

I hereby authorize and request medical records are released from:

Name of Facility: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone: ____________________

Fax: ____________________

To release the following records for the patient:

Patient Name: ____________________

Address: ____________________

DOB: ____________________

SSN: ____________________

Covering the period of treatment:

- Complete Files
- From _____/_____/_____ - _____/_____/_____

Records to be released:

- Clinical Notes
- Radiology Reports
- Other
- Please Specify ____________________
- Lab Results
- Medication Lists
- Immunization
- Hospitalization Summary

____________________ ____________________

Patient's Name (Please Print) **DOB**

____________________ ____________________

Signature of Patient, Parent, or Legal Guardian **Date**