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Medical Records Release Authorization

(Please Fill In Shaded Areas)

Authorization for Use/Disclosure of Information

I ______________________ voluntarily consent to authorize my health care
(Your Name)

Provider ______________________ to **RELEASE** ☐ **REQUEST** ☐
(Insert Dr.'s Name releasing/requesting my Medical Record) (Check Appropriate Box)

my Health Information during the term of this Authorization to the recipient that I have identified below.

____
Recipients Name

Medical Records Sent To: I authorize my health care information to be released to the following recipient:

Recipient Name
Address

Office/Fax Office Fax

Medical Records Requested From: I authorize my health care information to be requested from the following Provider:

Providers Name
Address

Office/Fax Office Fax

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information:

Term: I understand that this Authorization will remain in effect from the date of this Authorization for a term of **1 year.**

Signature Patient/Legal Guardian/Legal Rep | Date | Signature of Witness

Please Date This Document