

## 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: \_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Complete Records           | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes        |
| <input type="checkbox"/> Care Plan                  | <input type="checkbox"/> Lab Reports        | <input type="checkbox"/> Radiology Reports     |
| <input type="checkbox"/> Pathology Reports          | <input type="checkbox"/> Treatment Record   | <input type="checkbox"/> Operative Reports     |
| <input type="checkbox"/> Hospital Reports<br>below) | <input type="checkbox"/> Medication Record  | <input type="checkbox"/> Other (please specify |

**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: \_\_\_\_\_

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

\_\_\_\_\_

**Signature:**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Patient Date of Birth or Social Security Number

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority