Medical Records Release

Patient First Name:	Patient Last Name:
Date of Birth:	Phone:
Address:	City / State / Zip:

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:	
Phone Number:	Fax Number:
Facility Address:	City / State / Zip:

Information to be Released:

( ) Between the dates of:	
( ) Progress Notes / Provider Notes	
( ) Lab Reports / Pathology	
( ) X –Ray reports	
( ) X – Ray films / MRI	
( ) Other (specify Content and dates):	

This information may be disclosed and used by the following individual or organization:

Release to:	
Phone Number:	Fax Number:
Address:	( ) Please mail records ( ) Please fax record

Acknowledgement of understanding:

- I understand the expiration date of this authorization is one year.
- Understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- Understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- Understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.
- Understand I will receive a copy of this from after I have signed it

Signature of Patient, Parent of Minor, or personal Representative ______ Relationship ______ Date ______

Authorization for Use and Disclosure of Protected Health Information