Medical Record Release Form

Patient Information

- **Full Name:** _____
- **Date of Birth (MM/DD/YYYY):** _____
- **Social Security Number:** _____
- **Address:** _____
- **City:** _____ **State:** _____ **Zip:** _____
- **Phone Number:** _____
- **Email:** _____

Authorization

I, _____, hereby authorize _____ (Name of the Institution holding the records) to release my medical records to:

- **Name of the Recipient:** _____
- **Institution/Organization:** _____
- **Address:** _____
- **City:** _____ **State:** _____ **Zip:** _____
- **Phone Number:** _____
- **Fax Number:** _____
- **Email:** _____

Information to be Released

- ☐ All medical records
- ☐ Lab results

- ☐ Imaging reports
- ☐ Treatment plans
- ☐ Other (Please specify): _____

Purpose of the Release

- ☐ Continuing medical care
- ☐ Insurance purposes
- ☐ Legal representation
- ☐ Personal use
- ☐ Other (Please specify): _____

Expiration of Authorization

This authorization will expire on (Date): _____.

Patient Rights

- I understand that I have the right to revoke this authorization at any time by notifying the releasing institution in writing, except to the extent that action has already been taken based on this authorization.
- I understand that the information released is subject to re-disclosure by the recipient and might not be protected by federal privacy regulations.
- I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Signature

- **Patient's Signature:** _____
- **Date:** _____
- **Legal Representative Signature:** _____

- Relation to Patient: _____
- Date: _____