Patient Release Form for Medical Records

Patient Information

Name: _____

Date of Birth: _____

Phone Number: _____

Email: _____

SSN (last four digits): _____

Medical Provider Information

Provider Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical Records to Be Released

[ ] Full Medical History

[ ] Immunization Records

[ ] Surgery Notes

[ ] Mental Health Records

[ ] Lab Results

[ ] Other: _____

Purpose of Release

[ ] Transferring Care

[ ] Legal Request

[ ] Insurance Request

[ ] Personal Use

[ ] Other: _____

Signature of Patient/Guardian: _____

Date: _____