**Physician Medical Records Request Form**

**Patient Information**

| **Field** | **Details to Fill** |
| --- | --- |
| **Full Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Contact Number** |  |
| **Email Address** |  |

**Records to be Released**

| **Record Type** | **Date of Service** | **Specific** **Notes** | **Delivery Method** |
| --- | --- | --- | --- |
| **General Records** |  |  | **Email ☐ Mail ☐** |
| **Diagnostic Results** |  |  | **Email ☐ Mail ☐** |
| **Imaging (X-ray, MRI)** |  |  | **Email ☐ Mail ☐** |
| **Lab Reports** |  |  | **Email ☐ Mail ☐** |
| **Prescription Details** |  |  | **Email ☐ Mail ☐** |
| **Immunization Records** |  |  | **Email ☐ Mail ☐** |
| **Specialized Treatment Notes** |  |  | **Email ☐ Mail ☐** |
| **Other (Specify)** |  |  | **Email ☐ Mail ☐** |

**Authorization
I authorize the release of the specified medical records to the designated recipient:**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
☐ I confirm I understand this request complies with medical privacy regulations.**