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.**