**Release Form Medical Template**

#### **Patient Information**

**Full Name: \_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_  
Phone Number: \_\_\_\_\_\_\_\_\_\_  
Email: \_\_\_\_\_\_\_\_\_\_**

#### **Authorization for Release of Medical Information**

**I, \_\_\_\_\_\_\_\_\_\_, authorize the release of my medical records to the following individual(s) or entity:**

**Recipient Name: \_\_\_\_\_\_\_\_\_\_  
Recipient Address: \_\_\_\_\_\_\_\_\_\_  
Recipient Contact: \_\_\_\_\_\_\_\_\_\_**

#### **Scope of Release**

**☐ Full Medical History  
☐ Specific Records (List Below)  
☐ Lab Reports  
☐ Imaging and X-Ray Reports  
☐ Treatment Plans**

#### **Purpose of Release**

**☐ Continuing Medical Care  
☐ Legal Purposes  
☐ Insurance Claims  
☐ Personal Use**

#### **Acknowledgment**

**I understand that my records will be shared as per my request and I have the right to revoke this authorization at any time.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_**

**Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_**