**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: \_\_\_\_\_\_\_\_\_\_**