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**

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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: __________

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