Medical Records Release

(Name of Patient) _____ (Birthdate) _____

(Street Address) _____ (City, State, ZIP Code) _____

Authorizes: **Release of Records to:**

(Name of Physician) _____ (Name of Physician) _____

(Name of Health Care Facility) _____ (Name of Health Care Facility) _____

(Street Address) _____ (Street Address) _____

(City, State, ZIP Code _____ (City, State, ZIP Code) _____

Information to be Released:

- ☐ All Clinic Records
- ☐ Eye Records
- ☐ Office Notes
- ☐ Photographs
- ☐ Visual Fields
- ☐ X-Ray Reports
- ☐ Immunization Records
- ☐ X-Ray Films (Specify) _____
- ☐ Allergy Records
- ☐ Lab Reports
- ☐ Electrocardiograms
- ☐ Other (Specify) _____

List other facilities records to be included when releasing for the purpose of continuing medical care:

_____

For the Following Dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- ☐ Mental health
- ☐ Developmental disabilities
- ☐ Alcoholism
- ☐ AIDS test results
- ☐ AIDS-related disease diagnosis
- ☐ Drug abuse
- ☐ Other

Purpose or need for disclosure: (check applicable categories)

- ☐ Further medical care
- ☐ Application for insurance
- ☐ Disability determination
- ☐ Payment of insurance claim
- ☐ Vocational rehabilitation evaluation
- ☐ Legal investigation
- ☐ Personal
- ☐ Other

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records. _____
(Alternate date if not one (1) year)

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____ Date _____
(If signed by person other than patient, state relationship and authorization to do so)

_____ _____
(Authorized signature) (Relationship)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal ☐ Legal guardian ☐ Next of kin of deceased