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MEDICAL RECORDS RELEASE

Request for Copies

LAST NAME_________________________________ FIRST NAME______________________________ MI______

ADDRESS____

Address City State Zip

PHONE ______-______-________ EMAIL ADDRESS ____

SOCIAL SECURITY NUMBER _________-________-___________ DATE OF BIRTH _ _ / _ _ / _ _ _ _
M M D D Y Y Y Y

I hereby authorize the release of my Protected Health Information as follows:

FROM: NAME / TITLE____

ADDRESS____

CITY____ STATE__________ ZIP______________

PHONE______-______-________ FAX______-______-________

TO: NAME / TITLE____

ADDRESS____

CITY____ STATE__________ ZIP______________

PHONE______-______-________ FAX______-______-________

Type of Access Requested:

- ☐ Complete Chart
- ☐ Physicians Orders
- ☐ Imaging / Testing
- ☐ History & Physical
- ☐ Billing Records
- ☐ Operative Reports
- ☐ Progress Notes
- ☐ Other _____________________________

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that the action has already been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclose by the recipiant and no longer protected. I understand that there may be a fee involved with the fulfillment of this request. I understand that the term Complete Chart for release of Protected Health Information means that only records generated by this office will be released.

Signature: ____ Date: ______________________

Patient / Parent / Legal Guardian