

Patient Authorization for Release of Medical Records

Date: [Date]

Patient Information:

Full Name: [Patient Name]

Date of Birth: [DOB]

Social Security Number (optional): [SSN]

Phone Number: [Phone Number]

To:

[Name of Healthcare Provider/Facility Holding the Records]

[Address]

[City, State, Zip Code]

Release Records To:

[Name of Recipient/Facility]

[Address]

[City, State, Zip Code]

[Fax/Email if applicable]

Purpose of Release:

[e.g., Personal Use, Legal, Continued Care, Insurance]

Information to be Released:

☐ Complete Medical Record

☐ Records for specific dates: [Insert Dates]

☐ Lab Results/Imaging Reports

☐ Billing Records

☐ Other: [Specify]

Authorization:

I hereby authorize the release of my protected health information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by providing written notice. This authorization will expire on [Date] or [Specific Event].

Signature:

Patient Signature (or Legal Representative)

Printed Name: [Name]

Relationship to Patient (if applicable): [Relationship]