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MEDICAL RECORDS RELEASE FORM

Date: _____
Patient Name: _____
Date of Birth: _____
Social Security #: _____
This Authorization is good for a period of 90 days from the original date signed.

Name of facility / physician where medical records should be released from:
_____

Phone #: _____ Fax #: _____

Patient / Guardian Signature: _____

I hereby authorize the above name facility/physician to release my medical records including psychiatric, alcohol or drug abuse information contained. Specifically the following records:
( ) Laboratory Reports
( ) Diagnostic Reports i.e. EKG, X-Ray ( )Discharge Summary
( ) History & Physical Notes
( ) Operative Reports ( ) Pathology Reports ( ) Progress Notes ( ) Office Notes
( ) ACOG Forms ( ) HIV test results ( ) Other

The information is needed for the following purposes:
( ) Continued care by the receiving facility/physician
( ) Claims settlement with insurance company
( ) Needed to receive aid by the above named agency
( ) Legal proceedings or advice
( ) Personal use ( ) Other

*The records will be released to:

Office / Physician: _____

Office Phone #: _____ Office Fax #: _____