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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 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: ____________________

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