

MEDICAL RECORDS RELEASE

1. Patient Information

Full Name: _____ [Enter full legal name]

Date of Birth: _____ [MM/DD/YYYY]

Phone Number: _____ [Enter phone number]

Address: _____ [Enter complete mailing address]

2. Recipient of Records

I hereby authorize the release of my medical records to the following individual or organization:

Name or Organization: _____ [Enter name or healthcare provider]

Address: _____ [Enter address]

Phone Number: _____ [Enter phone number]

Fax Number (if applicable): _____ [Enter fax number]

3. Releasing Party

I authorize the release of medical information from the following provider or healthcare facility:

Name or Facility: _____ [Enter name of doctor or medical institution]

Address: _____ [Enter address]

Phone Number: _____ [Enter phone number]

Fax Number (if applicable): _____ [Enter fax number]

4. Purpose of Disclosure

- Personal Use
- Continuity of Care
- Legal
- Insurance

Other: _____ [Specify reason]

5. Information to Be Released

All medical records

Records from the following date range: _____ [Start date] to _____ [End date]

Specific information only (check all that apply):

Laboratory results

Imaging/radiology reports

Mental health records (if applicable)

HIV/AIDS testing and treatment

Drug/alcohol treatment records

Other: _____ [Specify]

6. Expiration and Revocation

This authorization will expire on: _____ [MM/DD/YYYY or specify event, e.g., "completion of treatment"]

I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon it.

7. Acknowledgment and Signature

I understand that:

I may refuse to sign this authorization.

My treatment or payment cannot be conditioned on signing this authorization (unless allowed by law).

Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature of Patient or Legal Representative: _____

Full Name of Signatory: _____ [Enter name]

Relationship to Patient (if not self): _____ [Specify relationship]

Date: _____ [MM/DD/YYYY]

8. Witness (if required)

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Witness Signature: _____

Witness Name: _____ [Enter name]

Date: _____ [MM/DD/YYYY]

This authorization complies with the U.S. Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy laws.

This document is provided for general informational purposes only and does not constitute legal advice. You should consult with a licensed attorney or qualified legal professional in your jurisdiction to address your specific situation and ensure compliance with applicable laws.