Authorization to Disclose Medical Records

I hereby authorize _____ (Healthcare Provider) to release my medical records to:

Name/Organization: _____

Address: _____

Phone: _____

Patient Name: _____

Date of Birth: _____

Medical Record Number (if known): _____

Information to be disclosed (check all that apply):

- ☐ All Medical Records
- ☐ Laboratory Results
- ☐ Imaging Reports
- ☐ Discharge Summary
- ☐ Other (specify): _____

Purpose of Disclosure:

- ○ Continuing Care
- ○ Personal Use
- ○ Insurance
- ○ Other (specify): _____

This authorization will expire on: _____ (if left blank, one year from date of signature)

Signature of Patient/Legal Representative: _____

Date: _____

Relationship to Patient (if not self): _____