Authorization for Medical Records Release

I, _____, hereby authorize the release of my medical records as specified below.

Date of Birth: _____

Address: _____

Phone Number: _____

Release Records To:

Name/Organization: _____

Address: _____

Phone: _____

Information to be Released:

- ☐ Entire Medical Record
- ☐ Medical History
- ☐ Lab Results
- ☐ Immunization Records
- ☐ Other (specify): _____

Purpose of Release: _____

This authorization is valid until: _____

I understand that I may revoke this authorization at any time in writing.

Signature of Patient/Representative: _____

Date: _____