Medical Records Authorization Form

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Recipient Information

Name/Organization to Receive Records:

Recipient Address:

Recipient Phone Number:

Details of Request

Purpose of Disclosure:

Records to be Released (describe specifically):

Dates of Treatment (if applicable):

Authorization

☐ I hereby authorize the release of my medical records as specified above.

Signature:

Date:

Submit