Medical Records Release Authorization Form

Patient Information

Full Name:

[   ]

Date of Birth:

[   ]

Phone Number:

[   ]

Address:

[   ]

Recipient Information

Recipient Name/Facility:

[   ]

Recipient Address:

[   ]

Recipient Phone Number:

[   ]

Authorization Details

Purpose of Release:

[   ]

Information to be Released:

☐ All medical records

☐ Specific records (please specify):

[   ]

Authorization Signature

Signature:

[   ]

Date:

[   ]

[Submit Authorization]