Release of Medical Records Authorization

Patient Name:

[   ]

Date of Birth:

[   ]

Phone Number:

[   ]

Patient Address:

[   ]

Healthcare Provider or Facility:

[   ]

Release Records To (Name/Organization):

[   ]

Recipient Address:

[   ]

Purpose of Release:

[   ]

Information to be Released:

☐ All Medical Records

☐ Specific (please specify below):

[   ]

Dates of Service:

[   ]

Patient Signature:

[   ]

Date Signed:

[   ]