Authorization to Release Medical Records

I hereby authorize _____ to release my medical records to:

Recipient Name/Organization: _____

Address: _____

Phone Number: _____

Fax Number (if applicable): _____

The information to be released includes:

- ☐ All Medical Records
- ☐ Laboratory Reports
- ☐ Imaging Reports
- ☐ Other (please specify): _____

Purpose of Disclosure: _____

This authorization will expire on: _____

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____