Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient name: _____

Date of birth: _____

The information you may release subject to this signed release form is as follows:

☐ Entire medical record (intake forms, treatment notes, billing, labs, etc)

☐ Only: _____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care (choose either email or mailing address):

☐ Email address: _____

Or mailing address: (Please note: $10 fee applies for printing/mailing)

☐ Name: _____

Address: _____

City, State, zip code: _____

The purpose/reason for this release of information is as follows:

_____

Consent:

_____
Printed patient name

_____
Patient signature

_____
Date signed